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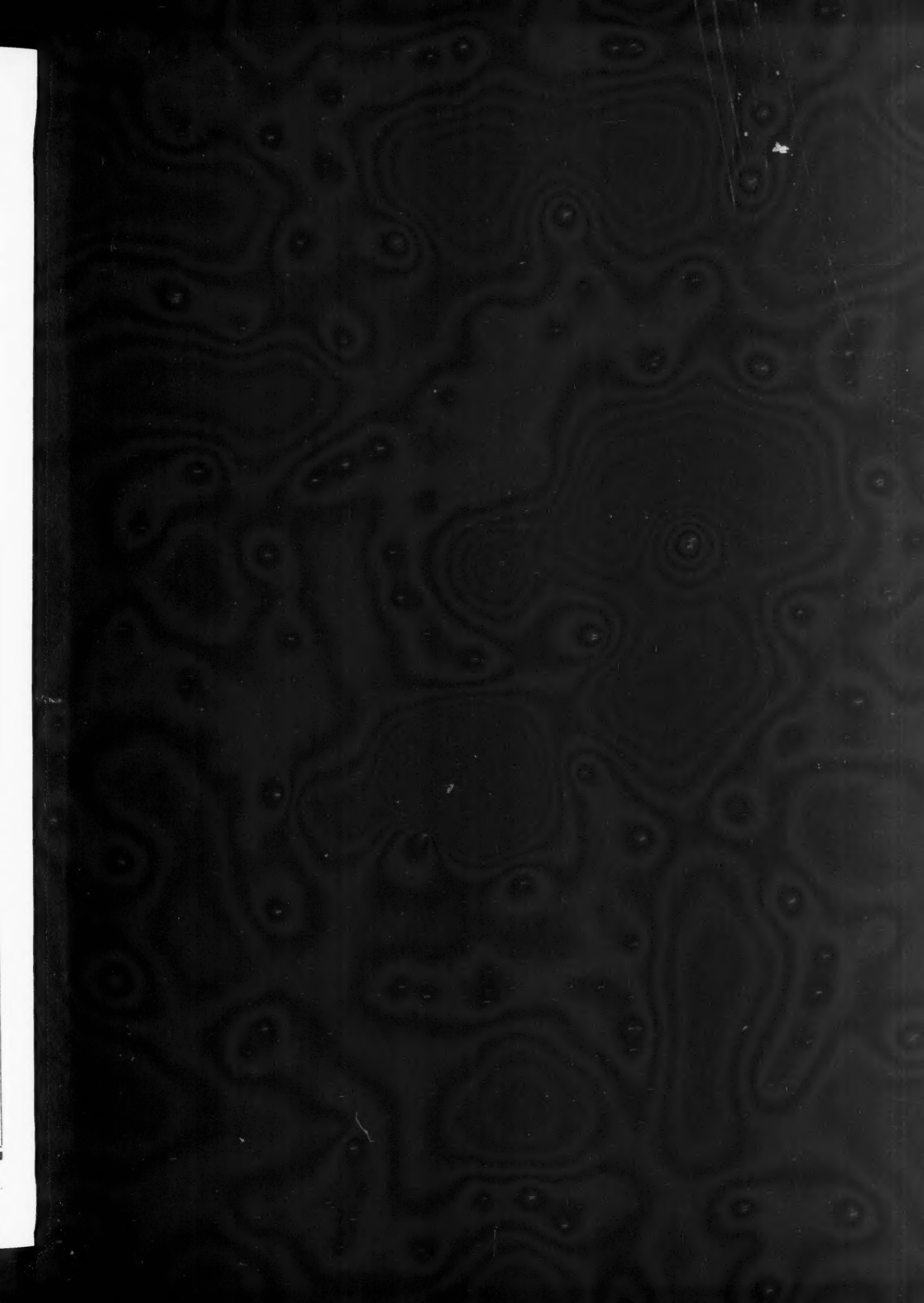

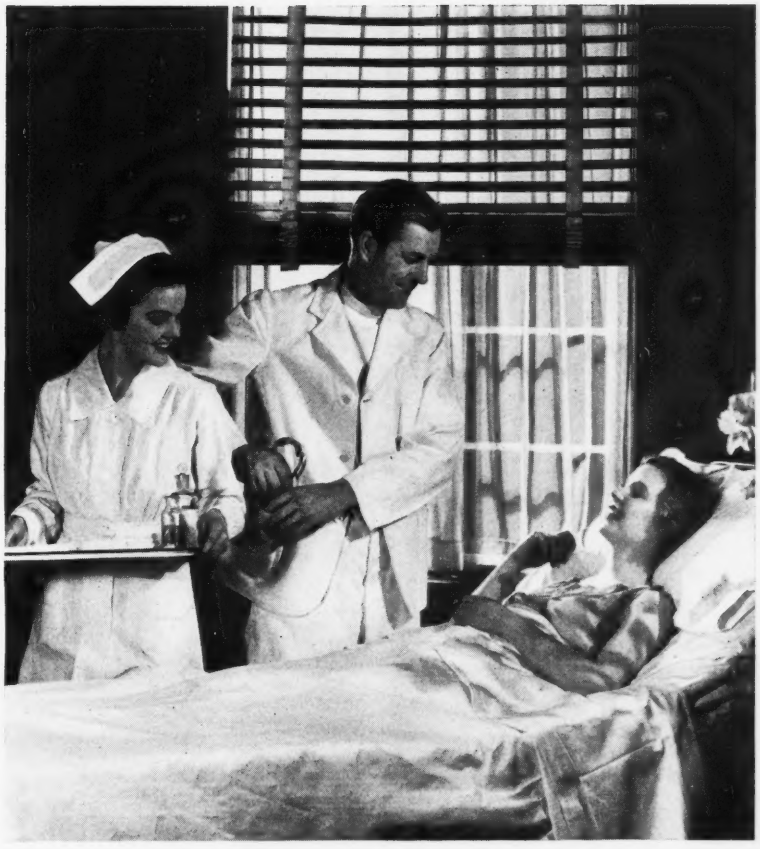

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CONTENTS

INDEX TO ADVERTISERS

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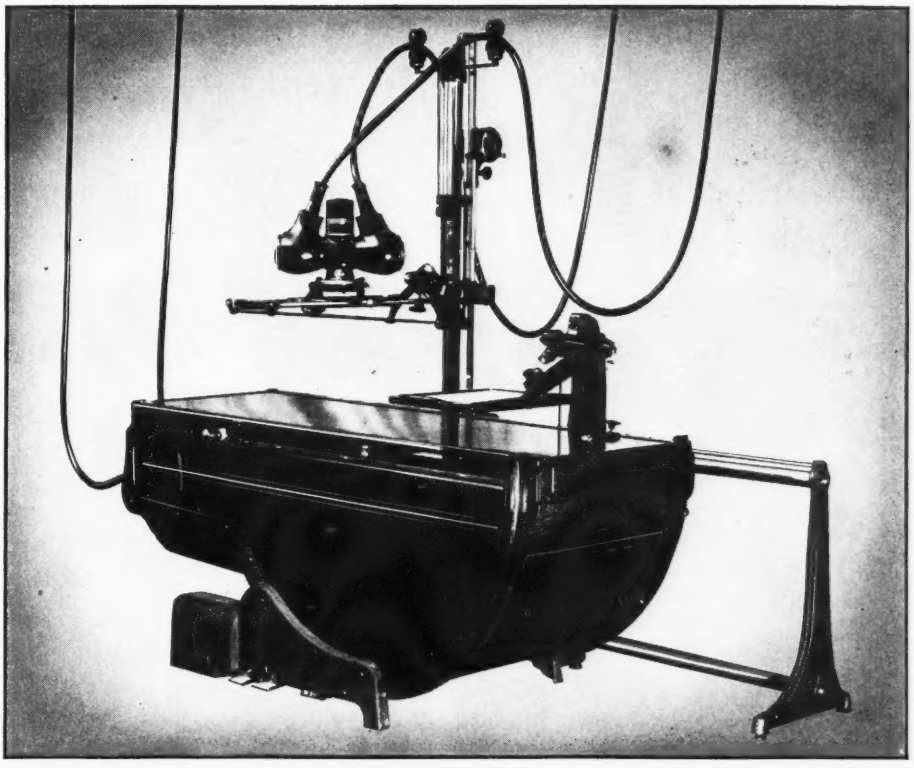

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A technique for administering

A *New* ANAESTHETIC GAS

STUDIES of Cyclopropane anæsthesia have now been conducted for several years by numerous competent investigators; and increasing clinical experience indicates that Cyclopropane is a valuable anæsthetic agent. Induction is pleasant and rapid. Breathing is very quiet. Circulation is not depressed. Relaxation is comparable to that obtained with Ether. There are evidently no untoward effects on lung tissue (diseased or normal), mucous membranes, liver or kidneys. Recovery is rapid and resembles awakening from normal sleep. Postoperative morbidity compares very favorably with other anæsthetic agents. It is the only gas sufficiently potent for major abdominal operations.

Outline of Technique

The completely closed carbon dioxide absorption technique is the method generally used in the administration of Cyclopropane; which in fact is at present the only practical method. This requires a gas machine equipped with a carbon dioxide (soda lime) absorber and a suitable device for accurately measuring the flow of the gases.

The technique is very exacting. For satisfactory anæsthesia and economical results, it is important that the face mask be tight fitting and that no leaks be permitted at any point in the closed system. A careful technique is also necessary because of the potency of Cyclopropane in low concentrations, the absence of respiratory stimulation, and the fact that dangerous concentrations may be given without cyanosis.

Cyclopropane is generally administered in a ratio of 15 per cent Cyclopropane to 85 per cent oxygen; and anæsthesia may in some cases be maintained with as low a concentration as 4 per cent Cyclopropane and 96 per cent oxygen. In this respect Cyclopropane differs considerably from other gases which are given in much higher concentration; and for this reason those who are accustomed to using nitrous oxide or ethylene will need to exercise the greatest care to avoid over-dosage with this gas.

The Waters' Technique

The technique developed and employed by Waters and his associates[1] is described as follows:

"Administration is begun with a very rapid flow of oxygen (8 or 10 liters per minute) into the mask as it is placed on the patient's face and continued until the mask, canister and bag are sufficiently filled to accommodate completely the patient's tidal excursion. At the same time, Cyclopropane is introduced at the rate of 600 or 700 cc. per minute in average cases and continued for from thirty seconds to two or three minutes. The addition of Cyclopropane is then stopped completely. An interval of several minutes must intervene before complete distribution to the tissues takes place and maximum narcotic effects result. In certain resistant individuals it may be necessary to give the gas for a few seconds at a more rapid rate, and in some very susceptible ones, or those heavily dosed with non-volatile agents, a slower flow during induction is indicated.

"During the period of maintenance, a constant slow flow of oxygen should be added, approximating as nearly as possible the metabolic demand of the patient. This usually varies between 250 and 400 cc. per minute. An air-tight contact of the mask on the face simplifies maintenance of smooth anæsthesia. A few minutes of observation usually suffice to determine the optimal constant flow of oxygen for a given patient. If physical signs indicate that the degree of narcosis resulting from the mixture originally used to fill the mask, canister and bag is insufficient, the flow of Cyclopropane may be resumed for a time sufficient to enrich the mixture properly. If, on the other hand, the degree of narcosis is too profound as evidenced by physical signs, a rapid addition of oxygen for a brief period will reduce the potency of the mixture inhaled. The necessity for maintenance of unobstructed respiration is quite as important as with other agents. Pharyngeal airways are frequently used for this purpose."

Danger Signals

Cyclopropane differs from the other inhalation anæsthetic agents in two important respects, which necessitate quite different interpretations from those commonly accepted.

In the first place, Cyclopropane has the potency of chloroform and ether but does not possess their irritant properties. For this reason a high concentration of Cyclopropane can be inhaled without producing laryngospasm, which, with some anæsthetic agents, is an early symptom of dangerous dosage. Lacking this warning sign, the anæsthetist must be careful not to rush the patient from one stage of anæsthesia to another without allowing sufficient time for full development of the effect from the dose administered.

Secondly, Cyclopropane is not a respiratory stimulant. Ether, nitrous oxide and ethylene commonly tend to produce an initial increase in rate and minute volume of respiration, up to the point of depression due to overdosage or oxygen-want. Cyclopropane, however, if administered with oxygen and without carbon dioxide excess, may produce no warning change in respiratory rate or minute volume until depressive doses are given. In fact, the high oxygen concentration used may even result in reduced minute volume in the early stages of administration.

Experience has demonstrated that Cyclopropane is safe only in ordinary anæsthetic concentrations. Waters and Schmidt reported that an average concentration of 42.9 per cent caused respiratory paralysis in the cases they studied, and that extreme respiratory depression may occur with as low a concentration as 21 per cent. Laboratory experiments by Seevers, Meek, Rovenstine and Stiles[2] have shown that Cyclopropane is of sufficient toxicity to cause circulatory death, even in the presence of adequate oxygen.

Preliminary Medication

It is the consensus of opinion among those who are familiar with Cyclopropane anæsthesia that much preliminary medication with drugs which tend to depress respiration is inadvisable, since Cyclopropane lacks the respiratory stimulating properties common with other anæsthetic agents. Furthermore, when such medication *is* used, its administration should be so timed that the maximum effect is obtained when the induction with Cyclopropane is begun.

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Amplons* mark a distinct advance in the marketing of anæsthetic gases by reason of their convenience, economy and safety.

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For complete information regarding the use of Amplon Cyclopropane Squibb, write to: E. R. Squibb & Sons of Canada Ltd., Professional Service Department, 36 Caledonia Road, Toronto, Ont.

References

[1] Waters, R. M., and Schmidt, E. R.; J. A. M. A., 103,975, Sept. 29, 1934.

[2] Seevers, M. H., Meek, W. J., Rovenstine, E. A., and Stiles, J. A.; J. of Pharm. & Exp. Thera., 51:1:1, May, 1934.

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POSTMORTEM EXAMINATIONS

By E. F. WHITMORE, LL.B.

THE Council on Medical Education and Hospitals of the American Medical Association in preparing its Essentials in a Hospital Approved for Interns, says "Inasmuch as the percent of autopsies has come to be recognized as an index of the educational activities in a hospital, no institution will be approved for the training of interns which does not have a record of autopsies of at least 15 per cent."

The Manual of Hospital Standardization (American College of Surgeons) urges that "the incidence of autopsies in any hospital is a good criterion of the scientific progress it is making." Dr. Malcolm T. McEachern has a strikingly similar sentence in his Hospital Organization and Management. These authorities illustrate the professional viewpoint.

Legally, the postmortem is the best example of a field of hospital activity where there is a noticeable divergence between the attitude of the profession and of the law. Here a striving for a high level of scientific accomplishment does not automatically tend to a compliance with legal requirements. The law has an arbitrary set of rules which require something beyond honesty of purpose and good scientific procedure. To discuss those rules is the subject of this article, which is really a short note on "How the Law Looks at Postmortems."

Three Cases are Cited

There are three Canadian cases in which a person, on whose relative a postmortem examination had been held, commenced an action against the persons responsible for the postmortem.

In the first—an Ontario case decided in 1899 — the action was brought only against the doctors who performed the postmortem. They were successful in their defence.

In the second—a Quebec case decided in 1907 — the action was commenced against a municipal hospital. The plaintiff who was the wife of the deceased, was successful.

The third was decided in Alberta in 1930. The husband commenced an action in respect of a postmortem performed on the remains of his wife against his wishes. The defendants were the physician who performed the examination and the undertakers, on whose premises the examination was conducted and who permitted it to be conducted. The final result of the case never appeared in the law reports, but the reported result of an interlocutory application (a type of preliminary skirmish), indicated that in all probability the plaintiff would succeed in recovering a substantial amount of damages.

A careful examination of the English reports has not revealed any similar case in England, although an action of this kind was apparently successfully maintained in Scotland in 1913. There are many instances of such cases in the American Courts. Some have succeeded; others have failed; almost unanimously they agree that such an action can succeed if the right facts are present.

The Alberta case is the one which brought the topic into prominence and demonstrated that a hospital cannot ignore with impunity the law's rather rigid but comparatively simple rules.

As this article is not designed for a legal periodical, I shall not attempt any scientifically precise enunciation of the law but will approach the question from the viewpoint of the lay reader whose interest will be only in the general practical implications. The Canadian cases are so few that it would be an unwarranted presumption to pretend that any complete and accurate analysis of the law were possible. Though the topic has been canvassed with much more completeness in the American courts, the decisions there are not always in agreement on matters of detail and are not of binding authority in Canada. Consequently, it is difficult to speak with certainty upon many of the more abstruse and uncommon points. The uncertainties and peculiarities of the law on this question were in 1905 noted by a member of the Supreme Court of Georgia in the following sentence: "It is not surprising that the law relating to this mystery of what death leaves behind cannot be precisely brought within the letter of all the rules regarding corn, lumber, and pig iron." In spite of this, the basic principles can be expounded with a fair degree of certainty.

From a purely juristic viewpoint, the action is one of the most interesting known to English law. It illustrates quite aptly two principles. The first is that many occurrences which the average man may genuinely and reasonably consider highly and inherently improper do not, of themselves, give rise to a claim for damages and cannot be designated as illegal per se. The second is that our law contains sufficient flexibility, adaptability, and vitality to indirectly remedy many situations which are not explicitly covered by its rather rigid and archaic basic concepts. Let me illustrate from the cases before us.

Ownership is Vital Legal Concept

It is said quite generally and with much accuracy that there is no property in a dead body, which means that a corpse has no owner. Ownership is one of our most vital legal concepts. Where there is no ownership, there is very commonly nothing of which the law will or can take cognizance. An indictment for stealing a wild animal, such as a fox, was almost sure to fail because such animals from the nature of things had no owners, even though they might have a fairly permanent residence on a person's land and by a gentleman's agreement between him and the rest of the world be regarded as his foxes. So it was that the law found it difficult to award damages in respect of an unauthorized postmortem. The corpse had no owner and there was no one to award the damages to.

As long ago as 1750, a rather singular case was decided upon this reasoning. An action was brought probably for obvious reasons, to recover possession of the bodies of Siamese Twins who had died. The action failed be-

cause the Plaintiff was not, and legally could not be, the owner of the subject matter of the claim.

Yet this rule must be taken with some qualification. This is evident from another quaint case decided in 1841. The deceased had died in jail, where he had been imprisoned for the nonpayment of debt. His executors who desired to bury the body demanded it from the jailer, who refused to deliver it until he had been repaid money due to himself from the deceased for articles supplied to him during his imprisonment. The Court gave the executors an order for the delivery of the body, thus holding that the proper persons have the right to possession of the body for the purpose of burial and, incidentally, that the deceased's creditors have no lien on his remains as security for their accounts.

In Canadian legal history as early as the Ontario case in 1899, legal ingenuity discovered a possible solution of the postmortem situation. To trespass on a man's land has always been a cause for awarding damages. Such is the sanctity which our law attaches to land. The trespass itself may be financially harmless, but other incidents which taken alone would be legally immaterial may make the trespass a cause of annoyance or financial loss which will serve to aggravate the damages. Thus, if I walk across my neighbour's land and while so trespassing, kill all the foxes that I can find, I may discover that my trespass which by itself would subject me to nominal damages only, results in a judgment for a large sum against me though my neighbour did not legally own one of the foxes. The keynote of the Ontario case was that the doctors had walked, probably very peaceably and without much outward opposition, into the Plaintiff's home and there performed the postmortem. As a result of this, the plaintiff was able to allege in the resounding phrases of legal pleadings that the defendants, without any legal authority, justification, excuse or license and against the will of the plaintiff, unlawfully entered his premises in the City of Toronto and remained there for a considerable time although ordered off by the Plaintiff. By themselves, those trenchant phrases which contained no mention of any postmortem would have resulted in the plaintiff recovering an infinitesimal amount of damages for trespass to land. They are the words which state that the defendant has done something legally wrong. However, the plaintiff was able to add in a similar strain that the defendants had cut and mutilated the dead body of the plaintiff's wife. That phrase introduces the postmortem and serves to inflate the damages to the point where they are worthwhile.

Had no further facts been presented, the doctors might have fought a losing battle. It was proven that the postmortem was done pursuant to a coroner's order in the course of an inquest and that absolved the defendants.

The Alberta case, thirty-one years later, reveals a development in legal thought which makes the reasoning a little more logical.

On July 21st, 1930, following the death of his wife, the plaintiff engaged the services of undertakers to make all preparations necessary for the burial of his deceased wife. The corpse was placed in the undertaker's funeral home and on the following day, the undertakers allowed a surgeon to enter its premises and without the consent of the plaintiff, to perform an autopsy on the body. Yet it was not the postmortem itself that paved the way to probable success on the part of the plaintiff. Of more initial importance was the fact that the plaintiff had undertaken the duty of burying his wife. As an incident to that duty, he had the right to the possession and control of the body until it was interred. The fatal mistake on the defendants' part was in interfering with the plaintiff's right to the custody and control of the remains though to a very slight degree. By itself, that would not have supported any substantial claim for damages though it might justify an award of a nominal sum. The unauthorized postmortem would swell the damages and as the plaintiff was able to wind up his pleadings by alleging that the surgeon by his unlawful acts in mutilating the said body and removing portions therefrom, had caused the plaintiff mental anguish and suffering, everything pointed to a moderately large award.

We need not spend any more time on the reasoning of the case which is remarkable more for its ingenuity than for its directness or cogency before turning to the practical results of these decisions. The following statements may be considered as satisfactorily accurate.

An unauthorized postmortem may give rise to a claim for damages on the part of the relative who had the right and duty of burying the deceased. The interference with his right to the custody and control of the body may be almost imperceptible and may not seriously interfere with the last rites, but it is sufficient to open the way to a lawsuit. No other person has any claim for damages.

The plaintiff will obtain judgment for nominal damages and costs even if he cannot prove any actual pecuniary loss. In truth, it will usually be impossible to prove any measurable amount of financial detriment.

The Possibility of Heavy Damages

A judgment for a larger amount will in most cases depend on the plaintiff's ability to prove mental anguish and suffering, i.e., injury to his feelings. The possibility of the plaintiff producing the necessary proof is something that must not be underestimated. A professional man accustomed to the bedside may not fully appreciate the exact feelings of the bereaved relative and may find that the judge, who, like the plaintiff, has had relatively little acquaintanceship with postmortems, is apt to be sympathetic towards a claim for reasonably heavy damages. The following words of a New York Judge may be a trifle rhetorical but they portray fairly accurately the judicial attitude which must be anticipated:

"The right is to the possession of the corpse in the same condition it was in when death supervened. It is the right to what remains when death leaves the body and not merely to such a hacked, hewed, and mutilated body as some stranger, an offender against the criminal law, may choose to turn over to the relative."

This danger is increased if the practitioner has disregarded an explicit prohibition against a postmortem.

Who is liable when the examination is illegal? That the pathologist who performed the autopsy is responsible is self-evident as he is the one who has personally done the act complained of. Where the examination is performed at a hospital, it also will usually be equally liable with the surgeon. There are two possible grounds of liability. The first is that the pathologist is retained by

the hospital for the express purpose of doing such work and that he is fulfilling his duty to his employer. Although usually in Canadian jurisprudence, the hospital is not responsible for the acts of the surgeon, yet in this situation the ordinary rule that the employer is responsible for the act of its employee appears applicable. The other ground is the one on which the undertakers were held liable in the Alberta case. The body has been entrusted to the hospital for temporary preservation and yet the hospital permits strangers to have access to it and to physically interfere with it. This line of reasoning is applicable even where the examination is conducted by an independent surgeon whose only connection with the hospital may be that he is on its medical staff.

Three possible defences present themselves. The first is a permit from the proper relative authorizing the proposed postmortem. The second is a coroner's order and the third is compliance with an Anatomy Act. (eg. R.S.S. cap. 169).

Naturally the most useful and common defence is that a permit was obtained. The permission need not be in writing but prudence suggests that it should be, as it facilitates proof as a matter of evidence at a later date and unless the negotiations are conducted by long distance telephone, it is usually as easy to obtain a written authorization as a verbal one. Hospitals have relied on a permission given during telephone conversations although the practice is by no means salutory as conversations conducted in the strained atmosphere existent after death are notoriously the subject of dispute. At least one hospital follows the practice of having a second member of the staff privately listen to the 'phone conversation in order to have an additional witness. Even that will not prevent disputes as the average person's complaint is never stilled by the fact that he has two persons to contradict. That only enables him to denounce two persons instead of one as misrepresenting the case and affords him an opportunity of alleging that he is the victim of an actual conspiracy. At the same time, it is a fairly safe precaution against actual litigation.

Signing of the Permit

The reasoning of the Alberta case suggests that the authorization should come from the person who will be taking charge of the funeral arrangements—usually, the spouse, parents or child of the late patient. Rarely is it necessary to be extremely careful as to the choice of the person who signs the permit because whoever conducts the business is usually the agent of the relative directly concerned. The typical case is where the deceased leaves a widow but a son signs the form. Even if he himself is not in a position to give a valid authorization, he is acting on behalf of the widow and has been entrusted by her to attend to whatever is necessary. There are many technical difficulties on this point but only infrequently are they of any moment and if we are to follow the line of utmost caution at this juncture, our postmortem average will dwindle to nothing.

It is a matter of discretion in the particular case what explanation should be given to the person who signs the permit. Where no explanations are asked for, none need be given. Where an explanation is requested, the hospital official must steer a nice course between giving so much information that the postmortem is refused and of giving such scanty vague information that the person is later able to say that he misunderstood the effect of what he was signing. A permit obtained following an incomplete or inaccurate description of the nature of the autopsy may have some legal value but it can be a source of much inconvenience.

There is a tendency to be less vigilant in cases where no immediate relatives are known to exist. This may be practically advisable in many cases but it must not be thought that the absence of near relatives forms a reliable safeguard. In the U.S.A. a brother and, I believe, a grandmother have been allowed to claim damages.

A coroner's order given in the proper manner and under the proper circumstances will, as indicated by the Ontario case, be a complete defence. It could hardly be otherwise. The exact circumstances under which a coroner may order a postmortem and the procedure which he must follow depend very largely on the law of the province. Hence, a detailed discussion would consume too much space. There are, for example, wide differences between the Saskatchewan statute and the Ontario statute on this point. As a practical solution, it is of minor value and could only be used occasionally in peculiar cases. The coroner's authority to order a postmortem has no independent existence but is incidental to his jurisdiction as to the holding of inquests. No hospital wishes to suggest that any percentage of its deaths require an inquest or even suggest the possibility of an inquest. An inquest is not primarily an investigation into the pathological cause of death. It is an enquiry directed to ascertaining whether the deceased or more often, any other person, is culpable of that death. It is devised not to clear up medical uncertainties but legal responsiblities. Even the considering whether an inquest is necessary conveys the implication that some human agency may be to blame for the death.

Most provinces have an Anatomy Act from which some assistance may be derived. Here again it is a question of studying the Statute passed by the province in which the hospital is located. It will be found that such statutes are limited in their applicability to the cases of persons who die destitute and friendless and that, moreover, they do not provide for postmortems in the true sense but for the delivery of bodies to physicians or medical colleges for the purposes of dissection.

In the absence of a statutory provision, it is very doubtful whether a postmortem authorization signed by the deceased during his lifetime has any validity after his death. The point does not appear to have been decided but the reason suggested is that a person cannot by will or otherwise legally dispose of his body after death. It has been decided, for example, that he cannot validly direct that it be delivered to a named person for cremation. Once death has supervened, any rights that exist are those of the relative and it is from the relative that the authorization must proceed. In England, however, if a person either in writing during his lifetime or verbally in the presence of two witnesses during the illness from which he died desires that his body be anatomically examined, the person having lawful possession of the body must cause the examination to be made unless the wife or nearest known relative requires interment without such examination. This, however, depends on the terms of a Statute, e.g., The An-

atomy Act, 1832, Sec. 8. Similar provisions may be found in the Anatomy Acts of certain provinces. It is noticeable that even under the Statute, the desires of the relatives have priority over those of the deceased.

These remarks will show that the main source of protection lies in permits signed by relatives of the patient. There are other potential sources such as a coroner's order but they do not furnish a satisfactory substitute in a useful number of cases. This does not mean that every case where the hospital does not obtain a permit will result in a loss to the hospital if a lawsuit ensues. There are still a number of possible defences but they have no place in an article which deals with preventive advice because mainly they arise accidently and incidentally so that until all the facts of the case have crystallized, it is hard to say whether or not they have come into existence.

To forecast a future trend in litigation about matters which do not arise from commercial transactions is never an easy thing to do but one might hazard the opinion that such actions will be more common in future than they have been in the past. From a plaintiff's viewpoint, it shows that given the right facts, the action may be successful. Any case that opens a new legal pathway usually acts as a forerunner for similar cases and hospitals should contemplate that hereafter their activities may be questioned more closely than they have been in the past when the belief was widely held that this was merely another example of a complaint for which there was no remedy.

Milk Board Prices and Hospitals

IN an effort to stabilize prices and control competition, various provincial governments throughout Canada have set up commodity Boards to which this power is delegated. One of the first of such Boards to be set up was a Milk Board. The effect in many provinces was to raise the price of milk to our public hospitals, despite the fact that the large volume purchases and the comparative economy of delivery warranted the favourable prices previously obtained by the institutions. In some provinces the hospitals were given exemptions from the regulations of the Milk Board and, in an endeavour to ascertain to what extent these exemptions have been made throughout Canada, an analysis of the regulations affecting hospitals was recently made by the Canadian Hospital Council.

British Columbia. There is a Milk Board and, as a result of its orders, the hospitals have been required to pay a large increase in the price of milk. In the case of the Vancouver General Hospital, the increased cost of milk amounted to $12,000 per year! On October the 3rd, 1935, the regulations were amended to provide, "That based on butterfat at 53c per pound the 'spread' which dealers shall add to the price paid by them for the regulated product when sold by them to any hospital shall be, on pasteurized milk with 3.25 to 3.4% butterfat content, nine (.09) cents per gallon, 4% to 4.15% nine cents per gallon, and 5% to 5.15% ten cents per gallon." In fact, this amounts to a reduction to the consumer of three cents per gallon.

Alberta. There is no provincial Milk Board.

Saskatchewan. There is a Milk Control Board, and the hospitals come under its provisions. Hospitals pay a fixed price of eight cents a quart for milk, the same as hotels and restaurants. The Saskatchewan Hospital Association has protested this arrangement to the Board.

Manitoba. There is a Milk Board in Manitoba, and the hospitals have been making strong representations to obtain exemption from its operation.

Ontario. There is a Milk Control Board. In a special memorandum, the Board states that "In a general way, hospitals are entitled to preferred treatment in the matter of milk requirements." In co-operation with the Ontario Hospital Association, schedules have been set up in many of the larger cities covering prices to hospitals. The Board has urged hospitals to use the regular channels of trade for their milk requirements but, where it has been deemed advantageous for the hospital to select "a controlled source of milk supply from a selected producer-distributor, it is recommended that this be on a basis representing a premium of at least 10% over the regular producer's schedule of prices." Where distributors are supplying hospital milk, producers are to be paid on the agreed price prevailing in that particular market.

Quebec. There is a Milk Board, and hospitals are not exempt from set prices.

New Brunswick. There is a Milk Board, and hospitals do obtain some exemption in that hospitals calling for tenders for the supply of milk may be given a 10% reduction on the wholesale price.

Nova Scotia. While there is a Milk and Cream Producers Protective Board, there are no regulations giving authority for a Control Board to fix milk prices .

Prince Edward Island. There is no Milk Control Board. In Charlottetown there is a Dealer's Milk Combine which regulates the price; hospitals pay one cent per quart less than the retail price.

In the *United States,* from information received from the American Hospital Association, the Joint Committee in 1934 was of assistance in securing a revision of the milk codes, eliminating excess distributor's profits and permitting hospitals to purchase as consumers instead of as retailers. The first work done in this respect was in the Chicago area, where such protests were made that Secretary Wallace himself went to Chicago and decided that the milk code being established in the Chicago area favoured only the distributor; the milk code was discontinued. In the Baltimore area, the Maryland State Dairymen's Association was made the controlling factor and

hospitals were classed as distributors and required to share in the administrative costs of the Dairymen's Association. After vigorous protest, this was adjusted. The New York State Hospital Association obtained exemption for hospitals using forty quarts or more per day, "Provided that the price charged for such milk or cream is not less than the appropriate class price required to be paid producers for such milk." In New Jersey, the hospitals were able to obtain a 10% discount. In Ohio, very little has been accomplished to relieve the burden on the hospitals, except that, where business was divided between two or more dairies, the price may be determined according to the total volume bought rather than that purchased from each dairy.

Inasmuch as milk is a commodity vital to the hospital and inasmuch as the hospital field must economize in every legitimate way, the arragements enumerated above should be of considerable interest to hospital workers.—G.H.A.

Training Hospital Personnel to Care for Psychiatric Patients

By O. E. ROTHWELL, M.D.,
Director, Psychopathic Department, General Hospital, Regina, Sask.

THERE can be no doubt that there is a considerable increase in mental illness. This has led those who have to do with general hospitals to ask the question: What part should we take to assist in this problem? There could be opened a division in which patients suffering from early manifestations of mental illness might be treated and so ward off a more serious and prolonged illness. In other patients some time may be required for observation in order that a more accurate diagnosis may be arrived at before taking the major step of admission to an institution. This brings up the question of training or arranging for suitable staff with which to carry out such a department of a hospital.

The title of this article might give the impression that the usual type of patient in a psychiatric ward of a hospital is vastly different from that one would meet in other branches of a general hospital. Some are for a time, but they soon adjust themselves, as do other patients. They are, as a rule, abnormal in their outlook on life and the view they take of the condition in which they find themselves. Are not all sick people different during sickness, in this regard? This may often be overlooked and the patients suffer thereby. In our estimation of patients we would be well advised to keep in mind that the mental reactions to environment will not likely be the same in sickness as in health. If this be true, all who have to do with physically or mentally ill people should be more ready to overlook the irritability and dissatisfaction expressed by patients.

First Steps of Training

The first step in training the personnel of a psychiatric ward should be to impress upon them that the patients are usually suffering from what is often described as sick personalities, and for that reason they must be given more consideration. They must expect to meet many peculiarities of conduct and behaviour which should be overlooked.

In the staff of a hospital, both the nursing and orderly, there will likely be a number who are naturally, by temperament and education, well suited to take training in this branch of work. The training in general nursing will always be of benefit to them and can be put to use during this service.

The question arises: Wherein does the care of mentally ill patients differ from those who are physically ill? In physically ill patients we are often only concerned with the body and disregard the patients' thoughts and how they react to them. The child in a hospital for the first time, or the mother with her young family at home, are examples of how some environmental factor will react on the healing processes. There is a psychic factor in all illness which must not be overlooked. Any experience or training in how to meet these problems will always be an asset to any general nurse.

The public, the medical profession and nurses have too long been unobservant of psychic symptoms and how to meet them. It is a far too common belief that anything "mental" should be treated in some institution or in some different way than ordinary sickness. This harks back to the old belief that punishment in some way must be meted out to these unfortunates before there will be any improvement. They must be segregated for safety and any contact with them is dangerous. Our attitude toward them has been one of doubt and fear, rather than helpfulness or sympathy. All staff members, both male and female, must be taught that their approach to this type of patient can only succeed when they give the impression that they are going to help rather than guard them. This being established in the minds of the staff, we will be well on our way to a successful readjustment of the patient to his environment, which is our goal.

Recording Observations

The system of observation and records made is more extensive in psychiatric work than in general work. As the mind gives expression to its thoughts by speech, action and attitudes, we must observe these more closely. A more

or less complete system of recording these must be developed. They must be reviewed daily and a record made. Closer observations must be made of all physical and mental activities. Sleeping, eating and the interests of the patients are also given consideration and recorded. Along with these there will be made a complete record of the physical condition—temperature, pulse, weight, etc. From these records one can make a more accurate estimate of the progress made, or otherwise. In the observation and study of the patient in this way, he or she comes to feel that it is not from idle curiosity, but in his or her interest, that it is being done. This gives to the nurse and attendant the best psychological approach upon which they can build to advise and correct any wrong habits of conduct and behaviour. The field of thought can often be better explored by a nurse and an attendant than even by a doctor. This puts their observations in the highest field of importance and they must be complete and accurate.

From what has been said nurses and attendants will come to feel their importance in the treatment and progress of patients. This is only right. It will increase the staff's interest in the work and the satisfaction that they are really helping patients to solve their personality problems and are making them better able to adjust themselves. No type of patient is more grateful for consideration shown by the staff than is the psychiatric patient after he has begun to recover. The rewards for service rendered are more often expressed by these patients than in other divisions of a hospital. There can be no greater reward for service rendered than the satisfaction a nurse and attendant has of seeing a disturbed patient settling down to satisfactory adjustment, when they know and feel it is largely due to their work. It makes them more ready to put up with the next unfortunate who will come under their care.

Importance of Selection of Permanent Personnel

The psychiatric ward being a division of a general hospital, it is presumed that the staff of this ward will rotate, as do the other divisions. As to how frequently this shall take place will depend on the size of the hospital and the number of divisions served. The course for nurses being three years should give at least three months of the thirty-six in this particular division. In that length of time the student nurse should have ample opportunity to see all the routine work and the various types of patients. It will also give an opportunity to those in charge to pick out staff who prove to be peculiarly adapted by temperament and natural ability for this work.

In the organization there will be some positions that will be filled by permanent employees who will not rotate. They will have supervision over the staff and will be equipped to give special instruction on treatment procedures and recording of observations of both mental and physical conditions. For these key positions, which will not be many, one will most likely have to look for applicants who have already had experience in service of a well organized psychopathic division in a general hospital. The choice of these few individuals will be important. While some experience is necessary, too much is not always an asset. Unless these people are going to be ready to mould themselves into a new organization and new ideas, they will not be a success. Every hospital already established has certain peculiarities, good and bad, and new staff who do not appreciate this do not always successfully adjust themselves. It will be necessary from time to time to bring in new ideas, but this can be done by post graduate training rather than by additions only.

Some special attention must be given to male nurses or attendants. Their responsibility is going to be greater than that of orderlies, as it will include nursing as well. While there will not be a large number of attendants, too much care cannot be given to their selection. Training, temperament, reliability and social standing must be taken into account. Previous experience is not entirely necessary, except that of hospital orderly training. The right type of orderly who wants to improve will, as a rule, work out satisfactorily when shown what is expected of him. This work should be placed upon a higher rating than is the orderly. The reason for this is that he will have greater responsibility and will require greater experience and training.

In the treatment of the usual cases seen in a psychiatric ward many diagnostic procedures are carried out wherein only fully trained nurses can be used. Other work, such as massage and occupational therapy, should be employed. These may require special training for the one who is going to supervise them, but that does not mean the employment of one person all the time. It could be arranged, as is done in some hospitals, by using part of the time of such an individual in the psychopathic department and the balance in the general wards.

Value to the Student

The training and experience which nurses get in a psychopathic ward will assist and add to their efficiency in other divisions. They will recognize and meet situations arising from time to time, without upsetting the patients and their friends, when they have some confidence in their own ability to cope with such conditions. With the increasing interest in this branch of medicine, no large hospital can afford to be without such a department for the training of the staff and to meet the demand of the public.

Reporting Hospital Day Activities

The National Hospital Day Committee earnestly requests that all hospitals send in a complete report of their Hospital Day activities so that the Committee may complete their files. Such report should include newspaper clippings from your local papers, any photographs that may have been taken together with notes by the superintendent. Canadian hospitals are asked to send their reports and clippings to Leonard Shaw, Canadian Member, Hospital Day Committee, Saskatoon City Hospital. It will be appreciated if these reports are sent in as soon as possible.

Obiter Dictum

The Sacredness of Human Life

A FEW weeks ago Canada was stirred as it has not been stirred since the War. Perhaps never before has this country from coast to coast followed with such breathless (and sleepless) interest and with such heartfelt sympathy, the epic struggle of those miners to release first three, then two, entombed men.

Effort and cost were of no consequence; the lives of the frantic rescuers seemed of little more. Perhaps never before has such a variety of modern scientific devices and equipment been utilized in effecting a rescue, and never before has the radio so fully demonstrated its power by keeping the thoughts of an entire continent focussed on this little spot in Nova Scotia. The courage of the rescue crew was in keeping with the finest traditions of the human race. Many are able to display courage of a high order under the excitement of the moment, but it is quite another matter to continue to face death hour after hour, day after day, exhausted and labouring under such trying physical handicaps as faced these human moles.

Yet all was done because of the sacredness of human life.

While deeply sympathetic with the plight of all three men, the hospital field was perhaps most interested, and pardonably so, in the fate of one of its own members, Dr. D. E. Robertson. As Chief Surgeon of the Hospital for Sick Children in Toronto, he has enjoyed an international reputation as one of the leading orthopedic surgeons in Canada. He too has known what it means to face death to save life; not only as a battalion officer, but in his own operating theatre he has risked his life to save some patient, usually a charity patient, knowing full well the possible consequences of a needleprick in a septic operation. So too have his nurses who, without question or hesitation have nursed virulently infectious cases back to health or until nursing was no more needed. So too have countless other nurses and doctors, yes and orderlies and ward aids, too! The Nova Scotia incident has proven to be one of the most dramatic incidents in Canadian history, but in a less spectacular fashion lives are being saved and lives are being risked every day in hundreds of hospitals and countless sickrooms.

Life *is* sacred. The finest traditions of our civilization have been built upon the willingness of one to risk his life for another. Our entire hospital work is based upon the fundamental principle of consecration to serve others. Because of this altruism in purpose, our hospitals and their medical and nursing staffs hold the respect and admiration of our people. If our hospitals and their associated professional groups are to continue in future generations to hold this loyal public support which they now enjoy, nothing must ever be permitted to dim this glorious and time-honoured singleness of purpose.

* * *

La Vie Humaine est Chose Sanée

Il ya quelques semaines, un événement singulier a remué le Canada tout entier, comme il ne l'a pas été depuis la guerre. Jamais dans notre histoire nous n'avons été unis par des sentiments de charité de sympathie comme nous l'avons été pendant que ces intrépides mineurs se dévouaient au risque de leur propres vies pour déterrer trois hommes engloutis dans une mine dans la nouvelle ecorse.

Aucun effort ni argent ne fat épargné, et jamais il ne s'est vu autant d'inventions scientifiques à l'usage des hommes pour éffectu un san vetage. Jamais non plus, la radio n'avait prouvé son pouvoir d'unir par la pensée et de maintenir sans interruption, les idées d'un continent entier concentrées sur un seul endroit.

L'équipe de mineurs firent preuve d'un courage égal aux plus grands faits de bravoure des annals humaines. Quoi que tout sympathique envers les trois malheneux enterrés, un d'eux attirait plus particulierement l'intérêt des membres de l'hôpital . . . le docteur Robertson.

Le Dr. Robertson chirurgien en chef d "l'Hôpital pour les Enfants" à Toronto, est comme d'à peu près tous les pays du monde, l'un des plus grands chirurgiens orthopédique du Canada. Lui aussi a su ce que c'est que de se trouver face à face avec la mort pour sauver une vie humaine. Sur le champ de bataille comme officier, et aussi sur son théâtre d'opérations chirurgique, il a souvent risqué sa propre vie pour sauver un patient.

L'incident qui a eu lieu dans la nouvelle ecorse est un des plus dramatique de l'histoire Canadienne, mais il y a tous les jours des hommes et des femmes qui risquent leurs vies quoique d'une manière moins éclatante à la vue du public, pour en sauver d'autres.

Oui, la vie humaine est une chose sacrée et tout l'ouvrage de nos hôpitaux est basé sur ce principe de dévouement envers le prochain.

Si nos hôpitaux doivent continuer à maintenir cet idéal de dévouement, il faut que rien ne viennent entraver leur glorieux progrès vers l'avenir.

A Responsibility

WHEN a governing body takes office in a public hospital such body becomes the final authority assuming all the privileges and responsibilities of absolute control. Its major responsibility at all times is to see that proper standards are maintained for the care of

the patient. If it deviates from this responsibility it commits a breach of public trust. The majority of governing bodies take their duties very seriously, resulting in well equipped institutions operated by efficient and well disciplined staffs, but regretably we find in many otherwise good hospitals a definite reluctance on the part of the governing body to control the medical staff, and who legislate so that the administrator also finds it difficult to exercise control over such staff.

The answer usually given when asked the reason for such attitude is that as a lay body they feel themselves incapable of efficiently controlling the work of a highly trained professional group. This viewpoint is, of course, wrong for there is no need to actually control the professional work other than to provide a form of self-government of the medical staff in the by-laws and then see that the spirit and text of such by-laws is lived up to. One of the governing bodies first duties is to appoint a medical staff. If it appoints men whose professional standards are poor it becomes morally and legally liable for any untoward result that may arise from such appointment. Because the board feels that it is not qualified to make the selection it must legislate that the medical staff shall investigate the standing of an applicant and recommend to the governing body the desirability or otherwise of such appointment. By such procedure the governing body utilizes the medical staff as an advisory group.

The responsibility of the board does not end with such appointment for it must see that the professional standard set is always maintained during the appointment and when it finds that a member of the staff has acted in such a way that the standard is lowered it must insist upon the medical staff investigating and recommending a suitable action to be taken by the governing body. It is a privilege for any medical practitioner to be appointed to a hospital staff and with this privilege goes the responsibility of complying with the standards of the hospital and observing its regulations. Any medical man not willing to accept such responsibility has no place upon the staff of any hospital regardless of its size. Governing bodies and administrators owe it to the community who support their hospital to be able to say at all times "We control this hospital completely and in such a way that we can assure you that only the highest standard of care to the sick is given whether it be medical, nursing, or any other type of hospital service; this safeguard we give to you as your right."

Can Student Nurses Take It?

IN our first sentence we must apologise for the phraseology of this heading, but when a leading newspaper blithely declares "The student nurses . . . just can't take it!" we cannot refrain from asking ourselves, "It that true?" Apparently the discussion was precipitated by the request of the superintendent of nurses of a large city hospital that shorter hours for student nurses be instituted. She reported an average loss, through illness, of 15 days per annum, and a contributing factor was considered to be the 58 hours on duty per week for day nurses and the 76 hours on duty for night nurses. The medical superintendent, in agreeing that shorter hours were advisable, is quoted as expressing doubts that the nurses of to-day have sufficient stamina to stand up to the work as did nurses in the past.

This comment raises an interesting question. The medical superintendent quoted is a man of keen observation and of long experience, and one whose opinion bears considerable weight. On the other hand, we have been under the impression that the nurse of to-day is particularly well-equipped, both physically and mentally. Speaking generally, the youth of to-day are healthier than previous generations at the same age. With the reduction of infectious diseases, including rheumatic fever, there is less residual heart and kidney disease; oral hygiene is better; the diet is better; the oncoming generation averages at least an inch taller than its parents. The nurse of to-day is more carefully selected than hitherto; she undergoes a more rigorous physical examination on entry, and her periodic check-ups during training are much more efficient; her housing and recreational facilities are better than ever before; her rest periods are more carefully preserved than hitherto; she works, on the whole, fewer hours than her predecessor and she is given better instruction on how to protect herself from infection.

On the other hand, with the increasing complexity of the curriculum and the abundance of scholarships and awards dangled before the student nurse, the strain of the academic side of the training period is becoming steadily greater; the tension engendered by the programme of social engagements crowded into the hours of so-called "relaxation" cannot but undermine the resistance of the individual. Discipline is not nearly as strict as in years past; the old idea of one eleven-o'clock late leave a month would seem ludicrous to-day. Certainly, there is a general trend everywhere for the individual to undertake less physical work than was considered to be the routine lot of our grandparents. Despite new athletic records, we probably are, on the whole, "softer" than were our parents. Tuberculosis among nurses would seem to be on the decline, thanks to vigorous supervision, but, according to Dr. E. L. Ross of Ninette, 1 in 17 of our pupil nurses will become sanatorium patients while still students or within a year of graduation.

We would like to have opinions from our readers upon this subject, particularly from those who know the nurse of a previous generation as well as the one of to-day. Can the 1936 nurse "take it?" Does she know anything of the tasks, responsibilities and hours routinely accepted by the pre-war nurse?

Life of Florence Nightingale Brought to Screen

Following the successful picturization of "The Life of Louis Pasteur," Warner Brothers are now filming the life of Florence Nightingale under the title of "White Angel." This portrayal begins with her early training in Germany and follows to the close of her life. A film of this nature should appeal to Directors of Nursing of our many schools and also to hospital administrators generally. Watch your theatre announcements for further details.

The Canadian Dietetic Association Holds First Annual Meeting

THE first annual meeting of the Canadian Dietetic Association held in Toronto, May 22nd and 23rd, got under way to a grand start with 250 dietitians registered, from points as far west as Alberta, and as far east as New Brunswick.

The general sessions, under the capable direction of the President, Lorena Richardson, manager of restaurants of Robt. Simpson Co. Ltd., Toronto, proved very interesting—discussions took place when many viewpoints of the members were freely aired. The officers for the coming year were elected to the complete satisfaction of all, as follows:

Hon. President—Annie L. Laird, Department of Household Science, University of Toronto.

Hon. Vice-President — Mabel Patrick, Dean of Home Economics Department, University of Alberta.

President—Ruth M. Park, Chief Dietitian, Montreal General Hospital.

President Elect—Kathleen C. Burns, Chief Dietitian Hospital for Sick Children, Toronto.

Directors—Helen Buik, T. Eaton Co. Ltd., Toronto;
Alice Stickwood, Macdonald College, St. Anne de Bellevue, Que.
Grace Sharpe, Ottawa Civic Hospital;
Kathleen Jeffs, T. Eaton Co. Ltd., Montreal;
Alice Pidgeon, Women's Residence, Queen's University, Kingston, Ont.
Ann Amos Thompson, Montreal.

RUTH M. PARK,
President, The Canadian Dietetic Association.

Dr. Truscott, of the Ontario Agricultural College, spoke at the Friday morning session, on "Frozen Fruits and Vegetables." His address, a resume of which will appear elsewhere, made those in attendance realize the increasing use which may be made of these in Canada.

Luncheon at noon was served in the Roof Gardens of the Royal York Hotel, with Mrs. E. B. Rutter of the University of Saskatchewan, presiding. Lovely surroundings, and a luncheon very appropriate for a warm day. Dr. F. W. Routley, of the Canadian Red Cross Society, spoke splendidly, and made any laggards present (we trust there were none) sit up and again realize the importance of nutritional work. The afternoon addresses, which will appear in summarized form, were of very great interest, and proved to be a real refresher course.

The informal dinners on Friday night, with the Convention divided into groups of Hospital Dietitians, Commercial Dietitians, and those engaged in Social Welfare, proved a great success from every standpoint. The food was delicious and very attractively served. The group dinners took the form of Round Table Discussions—a clearing house of ideas. The ideas advanced by different dietitians from various sources should prove a great help to all when they are "back on the job," working out their own problems. Such contacts and informal discussions are one of the most advantageous features of a Convention—too bad these cannot be held more frequently, and perhaps in smaller groups.

The Saturday morning session was given over entirely to a business meeting, when the question of membership was discussed. Afternoon tea was held in the Toronto General Hospital, with the Convention as guests of the Board of Trustees and a beautiful day it was for tea out of doors. The sandwiches and cake were so very dainty, and equally delicious. The biggest success were possibly the open-faced sandwiches made from ginger marmalade and pistachio nuts—a very good combination. We predict the early appearance of these in many points in Canada.

The annual banquet, held in the ballroom, was up to all expectations, and previous experiences. The chef's "grand coup" was a delicious fruit cup, brought in and served from a whole, hollowed pineapple, complete with crown, very attractive and palatable. Dr. Norma Ford, of the University of Toronto, gave us a review of the biology of genetics, with particular emphasis on the heredity of taste.

We all regretted that lack of time, due to a full programme and fuller discussion periods, did not allow as much time as deserved for visiting the exhibits. These form one of the interesting and practically instructive parts of the Convention. We were glad to welcome many familiar firms and become acquainted with new ones. The exhibits represented kitchen equipment, food products and educational material.

All in all every one rated the Convention a decided success. Our first Birthday Party augers well for the success of our Association.

Hospital Round Table

On Friday evening, May 22nd, during the Convention, the hospital dietitians met at an informal dinner for discussion of mutual problems. There were in attendance over 50 dietitians, with Kathleen C. Burns of the Hospital for Sick Children, as Chairman. Seated at the head

table were Winnifred Moyle of the Toronto General Hospital, Mary Chute, R.N., of the University of Toronto School of Nursing, Dr. Gladys Boyd of the Hospital for Sick Children, and Ruth Park of Montreal General Hospital. Other present were Annie L. Laird, University of Toronto; Mabel Patrick, University of Alberta; Mrs. Ethel Rutter, of the University of Saskatchewan; Lilian Sheridan, London; Jean Millar, Guelph; Claribel Hazlett, Christie St. Hospital, Toronto; Charlotte M. Large, Royal Victoria Hospital, Montreal; Beth Nichol, Montreal General Hospital; Eileen Morgan, Montreal General Hospital; Dorothy Shantz, Toronto General Hospital; Bernice Silverwood, Toronto General Hospital; Olive Argue, Saskatoon; Ethel Wark, Toronto Western Hospital; Jessie Pickersgill, of Winnipeg.

Dr. Boyd opened the discussion on ideal methods of teaching patients on special diets. Her opinion was that individual instruction of patients and patients' parents was most successful, especially where small groups were to be handled, owing to the difference in intelligence, background and education of persons being taught. Miss Nichol, of Montreal General Hospital, agreed that this method of individual instruction was most satisfactory in their hospital where bedside teaching was given. Due to the large turnover of patients, few were in the hospital during the convalescent period, hence group teaching was not possible. Miss Silverwood, of Toronto General Hospital, felt that group work and individual instruction was most satisfactory. Miss Harris of St. Catharines, told of a visit to a clinic at Portland, Oregon, where discussion of mutual problems was a feature and food preparation and variations in food and substitutes were given. The psyschological effect of finding other people with the same problems tends to encourage these patients in adjusting to their diet and lessens their feeling of social segregation. Miss Hazlett and Miss Argue spoke at this discusion.

Miss Mary Chute told of the method of teaching student nurses which has been adopted by their school. They use the case method where the student nurse takes complete charge of the patient throughout the entire day, including the servicing of meals and dietary treatment, nursing care, medication, dressing, etc. Under this method they felt that the student receives a correlation of theory with practice and reaches a more suitable understanding of all the requirements of the patient. Thus the dietary treatment forms a very important part and is given as individual instruction rather than by the Black system of class teaching. Miss Shantz, Miss Morgan, Miss Fleming, Miss Moyle and Miss Laird all spoke at this discussion.

Various opinions were expressed as to whether student dietitians should carry any teaching as part of their training or whether it should all be done by staff members, and it was felt that if any instructions were given by student dietitians it should be done under supervision of the teaching dietitian. Suggestions were made for special preparation and education of the dietitian to fit her for this work. Illustrative material and case studies were suggested as aids in teaching.

When the meeting adjourned it was felt that this type of informal discussion was of value in acting as a clearing house of ideas that would be of practical value and enable the dietitians to gather some ideas which could be adapted to their own particular needs and organization.

Commercial Round Table

An Informal Dinner for the Commercial Group of Dietitians attending the Canadian Dietetic Association Convention was held in the Royal York Hotel on Friday night, May 21st, 1936, with a record attendance. Miss Kathleen Kennedy, of the T. Eaton Co. Ltd., of Montreal, presided, and the meeting proved of great interest and enjoyment to all present. The choice of speakers was a most happy one, as their varied business occupations covered such a wide range of the Commercial Dietetic Field that the enthusiasm of the meeting was held at a high pitch throughout the entire evening.

The tremendous business opportunities along with the attendant difficulties of the catering business was presented in a very competent manner by Miss Elizabeth Crozier of The Robt. Simpson Co. Limited, Toronto. In a resumé of the work of that department from its very small beginning, she pointed out that by maintaining a high standard of food, cleanliness, efficiency of service, and prompt delivery, it had rapidly grown to its present tremendous volume of business, not limited to the city of Toronto, but now including all neighbouring towns.

Miss Gwendolyn Taylor, Dietitian at Loblaw Groceterias Co. Ltd., traced the development of the Self-Service Stores from its origin, as an idea in the mind of a clerk in one of the Hudson's Bay Stores to the present Company, which includes 112 stores in the Province of Ontario. She described the recently built and very up-to-date Cafeteria in the Head Warehouse in Toronto, where employees can obtain most attractive and nourishing meals at a very moderate price. Another interesting detail of her work was the testing of all new products of food used in the chain of Loblaw Groceterias before putting them up for sale, which has proved of great value to their customers.

A most unusual feature was Miss Ester Irvin's talk on her pioneer work with the C.P.R. Hotels throughout Canada. It is an immense field and her difficulties are exceedingly great but there is no doubt she is opening up new avenues of employment for future dietitians in hotel management, particularly with regard to salad and afternoon tea menu planning and supervision. It is the hope of Miss Irvin and the Canadian Dietetic Association, as a whole, that at some date in the not too distant future, Canadian hotels may realize the inestimable value of such a service, and that properly qualified dietitians may be equipped to undertake the responsibility of such a position.—E. Louise Brittain.

Social Welfare Round Table

On Friday evening, May 22nd, an informal discussion group met at the Royal York Hotel for dinner. About 20 persons met who are actively engaged in Nutrition work or are interested in this work. Margaret S. McCready was Chairman, and among those present were Marjorie Bell and Muriel Redmond.

Dr. Elizabeth Chant Robertson gave a paper which is reported elsewhere.

Service, courtesy and respect of confidences will bring you nothing but friendship.

A Criticism of Present Dietary Standards

Thirty-eight food elements are essential for normal nutrition. A lack of any one of these food elements will interfere with health, and a complete lack of any one will eventually result in the death of the individual. Studies undertaken at the Hospital for Sick Children, Toronto, and the Department of Paediatrics, University of Toronto, indicate that the average Canadian diet does not supply all of these food elements in amounts necessary for the optimal or highest possible level of health.

The water-soluble Vitamin B1 is widely but not abundantly distributed in ordinary foods. Also there may be considerable loss of this food substance due to its going into solution and being discarded in cooking water. The ready oxidation of vitamin C by heat in the presence of air necessitates the administration each day of some raw fruits or vegetables. Vitamin D is not present in appreciable amounts in ordinary foods. It would require 1560 servings of beets to give the vitamin D equivalent of 1 teaspoonful of cod liver oil or, if one prefers lettuce, a lettuce salad daily for about eleven years would furnish the vitamin D equivalent of 1 teaspoonful of cod liver oil. It requires 14 egg yolks as purchased in the open market in Toronto to furnish the vitamin D equivalent of 1 teaspoonful of cod liver oil. It is thus evident that it was intended that the human race should receive its vitamin D from sunshine. Unfortunately, due to our Canadian weather, for 6 to 8 months of the year, the average citizen of Canada receives very little vitamin D effect from sunshine. This lack in infants and small children results in the development of rickets with resultant bone deformities, and in the older child is a factor in the prevalence of tooth decay.

In regard to minerals, the supply of iron should not be left to chance. Recent work is indicating that not all iron in foods can be utilized by the body and that our ideas on iron metabolism will have to be revised. Fruits and vegetables, and such animal foods as liver, kidney and eggs are valuable as food sources of iron. Evidence is given to show that many Canadian children on what would be considered a good diet do not get an optimal amount of iron in their food. A lack of minerals, particularly calcium and potassium, results in a lack of tone of the intestinal tract with resultant delayed elimination.

From the above work it is indicated that the following food elements are possibly not being obtained by the Canadian child in amounts necessary for optimal health: Vitamin B1, Vitamin D, Iron, and possibly some of the other minerals.

Abstract of talk given by F. F. Tisdall, M.D., F.R.C.P. (c.), at the First Annual Convention of the Canadian Dietetic Association, Toronto, May 22nd and 23rd, 1936.

Frozen Fruits and Vegetables

The preservation by freezing of small fruits and some vegetables has developed into an important industry in the United States. In Canada however, the development of the industry has been much slower, and in most instances the pack is limited to strawberries for ice-cream flavouring, sour cherries for bakery use, and green peas for use in hotels and similar institutions.

As a consequence of the limited development of the industry here, Canadian dietitians have probably not had an opportunity to become acquainted with the rather wide choice of fruits and vegetables which are being preserved by freezing. In some instances they may have encountered inferior frozen products, or they may have used a pack for purposes other than for which it was intended, with the result that they have condemned the process.

The delegates at the Convention were told of the methods of preparation of such products, the kinds of fruits and vegetables suitable for frozen preservation, and recommended ways in which to use them. A partial list of fruits and vegetables which freeze satisfactorily is as follows: strawberries, raspberries, sour cherries, sweet cherries, peaches, apricots, blueberries, cranberries, corn, peas, beans, spinach, asparagus and cauliflower. Space does not permit a description of methods, but this information may be obtained either from the Federal Department of Horticulture, Ottawa, or from the Department of Horticulture, Ontario Agricultural College, Guelph, Ontario.

It should be emphasized that only certain varieties of each fruit and vegetables are best suited to preservation by freezing. Experimental work on varietal suitability is being conducted in the Ontario Agricultural College using fruits and vegetables from various parts of Ontario.

The acknowledged dietary qualities of fresh fruits and vegetables are retained in a relatively unchanged condition by the frozen-pack method of preservation. Consequently this method of preservation should provide a valuable source of supply to the Dietitian during the season when fresh material is unobtainable.

Summary of a paper presented by J. H. L. Truscott, Ph.D., Ontario Agricultural College, Guelph, at the Canadian Dietetic Association Convention, Toronto, May 22nd and 23rd, 1936.

Social Aspects of Nutrition

General evidence is presented of the bad effects on health and development of high carbohydrate, low mineral and low vitamin diets, such as the poorly paid are almost forced to buy. The use of whole wheat bread improves such a diet considerably. Milk, butter, eggs, vegetables, fruit and meat, which are the most valuable articles in our diets, are precisely the ones that are apt to be low in cheap diets. Much can, however, be accomplished by educating the public as to the best way to choose and prepare their food.

That the physical development of children is greatly influenced by their food is shown by the fact that the boys of upper and middle class boarding schools in England are on the average 5″ to 3″ taller than poorer boys attending commercial schools. During the war the average height and weight of boys in a large boarding school became lower because of unsuitable food. Children fed poorer diets have definitely less hemoglobin in their food than those fed adequate diets. They also suffer from more dental disease.

Striking improvements in height, weight, hemoglobin

(Continued on page 28)

Dietetic and Household Management in a Sanatorium

By HAZEL L. STEARNS,
Dietitian, Provincial Sanatorium, Charlottetown, P.E.I.

THE ability to adapt ourselves to conditions wrought by inexorable laws, and a firm belief in the Providence of God, has long been recognized as conspicuous characteristics of the people who dwell in the Island Province by the sea.

Cradled amid surroundings that call forth the best in human resourcefulness, we early learn that only through the application of virtues that the world to-day calls "outmoded" and "old fashioned" can we successfully grapple with the problems that beset us.

It was fidelity to known and proved principles, that enabled us to withstand the assaults of the terrible economic cataclysm of recent years, at a time when mighty states and powerful governments all but crumbled beneath the strain.

In the last decade, when the people of this Province were brought face to face with the grim reality of an unseen enemy in their midst, exacting an average toll annually of 93.6 human lives per 100,000 of their population, it was their ability to adapt themselves to meet the demands of the situation that enabled them to take up the challenge of this remorseless foe. Their abiding faith bade them never once look back, but press ever forward until the victory was won.

It is not within the scope of this article to depict in detail the gloomy outlook of 1931, when the Great White Plague hovered menacingly over the land, and shrinking incomes were ushering in a period of hardships for Government and people. Nor is it for me to describe the brave, and at times seemingly hopeless struggle, against overwhelming odds, by men and women who unselfishly dedicated themselves to the cause of health and humanity. It is, I think, sufficient to say, that the Provincial Sanatorium at Charlottetown, erected in 1931, has already reclaimed countless victims of Tuberculosis from premature graves, and made satisfactory headway against the hosts of Death.

It is rather with the Institution as it functions in its daily grind, that we deal here, and more particularly that part of its machinery that comes immediately under my supervision. And again it is our ability to adjust ourselves to the crisis, that is our inspiration in the somewhat less spectacular field of dietetics and housekeeping.

With a capacity for fifty-three beds, to meet the demands of the entire Province, there is always a waiting list for admission to the Sanatorium. When we consider the inroads already made by this disease when the Sanatorium was erected only five years ago, we do not need the assistance of a lively imagination to realize that the total number of those receiving treatment remains practically constant.

The duties of dietitian and housekeeper are united, and the combination of the two positions, while giving double responsibility, repays in the administrative experience one enjoys, coupled with the therapeutic angle, which, in a Sanatorium, presents its own particular problems. The dietitian has the additional satisfaction of knowing that her training and experience qualify her to obtain best results, when the two branches are combined under her department and she is directly responsible to the superintendent.

The planning of menus and arrangement of special diets, the supervision of the housekeeping activities throughout the Institution, the purchasing of all food supplies and the care of the linen and its repair, are all part of the daily routine. With the assistance of a co-operative personnel, and with careful vigilance this routine is carried on, and overlapping of duties is carefully avoided.

The dietary service is centralized, thus placing the entire responsibility for trays and nourishments in our main kitchen. This has meant a close check on all supplies and a minimum reduction in waste. While we boast the lowest per capita cost of any similar institution in Canada—$1.83 per diem—we abhor anything approaching parsimony. We never sacrifice efficiency on the altar of economy. That we operate at so low a cost does not mean that we stint here or pinch there, it means simply that expenditure is very closely checked, and that waste does not exist.

The dietitian has had her training in the purchasing of all household supplies, and, while balancing her budget, is thoroughly cognizant of the needs that arise and how to meet them. The grading of canned goods is familiar to her, and she knows what meets her requirements. With a comparison of the different price lists of the many commodities required in the institution, the purchasing can be done advantageously.

With generations of constant struggle against irrevocable economic rules behind us, we have developed thrift to the point, not alone of virtue, but of perfection. We nurtured this trait within us because it was necessary if we were to survive, and nothing is more natural than that it should be the guiding star in the economics that govern the financing of our hospitals and sanatoria.

But, as already intimated, the welfare of the patient must subordinate every other consideration, even economy. This in turn can only be accomplished by smooth running regulations directing the activities of a competent staff.

If a hospital, or any institution catering to human infirmities, is to function properly, the full co-operation of every individual employed on the various operating staffs is absolutely necessary. Due to the fact that our department is the very centre of the institution, the personnel must be carefully selected.

It is an axiom that a contented and healthful employee is by long odds the most valuable and most capable. Contentment and good health can only exist where the fundamental laws governing hygiene are recognized. In recog-

(Continued on page 26)

Dietetic and Household Management in a Sanatorium

(Continued from page 24)

nition of these truths the staff and employees are comfortably cared for in large airy rooms, well ventilated and properly heated, which contributes in no small measure to the efficiency of our staff.

Carefully prepared meals, served in bright, cheerful surroundings, play their part in keeping sound minds in healthy bodies. Privileges are enjoyed by the staff that would be quite impossible in larger institutions. Nor is the employee bound by irritating or unnecessary restrictions. Discipline, of course, is necessary, and correct decorum is demanded of each. Rules to insure this are enforced, and no one is exempt from them.

We arrange the weekly schedule so as to allow for definite hours off duty. Two weeks vacation, with pay, are allowed, and after an employee has been with us a certain length of time, a sick leave, with pay, is granted. At the same time we expect of them fidelity to duty, never to forget that dignity must not relax, and that correct deportment is necessary. We attribute much of our success in ministering to the sick to the efficiency which is possible only where these principles are recognized.

We are, at the best, composed of many contradictory characteristics. All of us who dwell upon this planet possess, in different degrees, our pet aversions, our little likes and prejudices, and these are not always governed by reason. Indelibly stamped upon our souls, these little "peculiarities," as people will call them, are often trifling in themselves, but to us, who have cherished them for years, they loom large in the horizon. They govern us in our relations with our fellow beings to a much greater extent than we care to realize.

Now place us in a hospital or sanatorium, sick, taken suddenly perhaps, from our homes and loved ones. Irritated by thoughts of a long illness, and chafing under restrictions and subordination to rules encountered for perhaps the first time, and these idiosyncrasies of ours are intensified and strengthened an hundred fold.

Whether our pet aversion is asparagus or green window shades, once we become distressed by illness we cherish it and pamper it as something that connects us with the good old days. Hence it is that the patient who loathes poached eggs and loves dill pickles, or the temperamental little girl suffering with diabetes, together with tuberculosis, who just cannot take vegetables, but must have sweets, presents a most baffling problem. This calls for tact, with firmness, and courtesy with sympathy, governed with plain common sense.

It must always be borne in mind in considering the needs of the tubercular patient, that the dietary treatment is of the utmost importance. With the long, slow recovery of health, and the unavoidable monotony of institutional life, the dietitian has to put forth every effort to avoid any routine in diet. The ravages of the disease leave so much work for the overtaxed body, that she realizes that carefully planned meals, together with pleasant surroundings, play an indispensable part in aiding the patient on the road to a cure. But, arrayed against us is the fact that the toxins produced in the body by the disease, nearly always impair the appetite. This amounts at times to a rebellion against food, and is one of the earliest symptoms of the disease. The indifferent appetite is the despair of the Sanatorium Dietitian.

All these factors make it necessary for the dietitian to study each patient as though his particular case presented an entirely new and different problem. In order to better meet his individual needs we ascertain his likes and dislikes, and, if necessary, and when possible, his prejudices are catered to where they do not hinder his welfare, or interfere with that of his fellow patients. Firmness of course, there must be, in the rigid adherence to know scientific laws in the treatment of the sick. It would be mistaken kindness, for instance, to permit the diabetic to satisfy an abnormal craving for some food forbidden by the physician, but with tact and kindness, these difficulties can be overcome. We do not stress these points to convey the impression that in our opinion a dietitian must meet strange difficulties in an extraordinary manner. We emphasize kindness and a sympathetic study of the patient, as most important factors in his ultimate recovery rather, because there is no other way.

Associated with the pleasantest recollections of our sanatorium life are those traditional holidays, with their respective characteristics. Thanksgiving, Christmas, St. Patrick's, Hallowe'en—all these carry with them fragrant memories of colourful occasions. Each with its symbols is dear to us, and awakes within us echoes of the past. Thus it is that in the Sanatorium Thanksgiving Day features its colourful turkey, Halloween is ushered in by grinning pumpkins and witches with brooms, St. Patrick's trip blithely along with the symbolic shamrock and Irishman's pipe. The Christmas festival, with the gaily decorated trees in every room, the Christmas stockings and all the many touches that impart the seasonal atmosphere, make a Yuletide in the institution not only an endurable, but a joyous day.

The trays are decorated appropriately, and something special in the way of flowers and confections are arranged. When the occasion is the birthday of a patient, a cake is prepared, the candles are there, and he, or she, is complimented. It may seem energy misdirected to devote time and effort to what some would call non-essentials, but the dietitian and her staff are more than repaid for their trouble. They know there can be no doubt about their importance.

We face the future with confidence, not only in our institutions, but in ourselves. If disease is to be conquered it will have been by our own industry. And above all, and over all, we Prince Edward Islanders will be guided in attaining our destiny by the light of Divine Providence.

Social Aspects of Nutrition

(Continued from page 21)

percentage and dental caries can be brought about by adding more milk and natural sources of vitamins and minerals to average diets.

Ample of the essential food stuffs can easily be produced in the world. The difficulty is in making them available to the whole population.

Abstract of paper presented by Elizabeth Chant Robertson, M.A., M.D., at the Canadian Dietetic Association Convention, Toronto, May 22nd and 23rd, 1936.

Exhibitors at the Convention of the Canadian Dietetic Association

Berkel Products Co., Limited, Toronto..
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Canada Starch Co., Limited, Montreal.
Canadian Canners Limited, Hamilton.
Canadian Honey Federation, Guelph.
Consolidated Beverages, Limited, Toronto.
Consumers' Gas Company, Toronto.
Cory Glass Coffee Brewer Co., (Division of Percy Hermant, Ltd., Toronto.)
Gibbons' Quickset Jelly Powders and Desserts, Toronto.
H. J. Heinz Co., Toronto.
Hobart Manufacturing Co., Limited, Toronto.
Kellogg Company of Canada, Limited, London, Ont.
Kraft Phenix Cheese Co., Toronto.
Lever Brothers, Limited, Toronto.
Milquo Company, (Vi-tone), Hamilton, Ont.
Oxo Company, Toronto.
Salada Tea Co., of Canada, Limited, Toronto.
St. Vincent Co-operative Arrowroot Association, Montreal.
Scientific Food Products, Limited, Toronto.
Shirriff's Limited, Toronto.
Silex Company, Hartford, Conn.
Soy Bean Products, Toronto.
Swift Canadian Company, Limited, Toronto.
Silverwood's Dairies, Toronto.
Topeka Tea Co., Toronto.
A. Wander Company, Peterborough, Ont.

Sunsoy Breakfast Food Has Valuable Qualities

A new food product, known as Sunsoy Breakfast Food, was introduced to delegates to the Canadian Dietetic Association Convention held in Toronto on May 22nd and 23rd.

The manufacturers of this cooked breakfast food, which is produced from the Soy Bean, state that tests show it is of exceptionally high nutritional value. These investigations indicate that Sunsoy has a minimum *Grade "A"* protein content of 38%; contains vitamins A, B, D, G and E; is definitely an Alkaline food; is mildly laxative and easily digested; is rich in phosphorus, calcium and iron. It contains the essential amino acids, minerals and salts and a substantial amount of lecithin (1.65 to 3%). Being low in carbohydrates and a non-starch product, it makes an excellent substitute for meat.

The high vitamin and protein value of this product indicates that it is possessed of special qualities as a food for children.

Unusual Group Hospitalization Development at Antigonish

By G. H. A.

THE little town of Antigonish in Nova Scotia is always doing something to make Canada sit up and take notice. For this there may be several reasons. First of all, it has a name which proves a stumbling block to the novice until he masters its euphonic cadences. (Antigonish, like many other Nova Scotian places, retained the original Micmac Indian name. It should be pronounced with the accent upon the first syllable and then wound up, as one writer puts it, with a flourish on the tail syllable—An-tigon-ish. It is said that the word means "place-where-bears-tear-down-branches-to-get-beechnuts.")

Of more importance, however, would seem to be the fact that Antigonish and the surrounding agricultural and fishing districts are peopled with virile Scottish stock and, moreover, are blessed with the presence of two unusually progressive institutions, St. Francis Xavier University and St. Martha's Hospital. The work of the Women's Auxiliary of this hospital has been widely and favourably known; perhaps it is the most extensive community organization ever developed by any hospital in Canada, the Aids organization having, when reported some time ago, over 80 branches! The health clubs developed by the Extension Department of the university, which clubs have been linked to a large extent with the hospital organization, have been of tremendous assistance in promoting health knowledge and hygienic practices among the rural and fishing communities. The practical work of the university Extension Department, with which activities the names of Prof. A. B. MacDonald and Father M. M. Coady will always be associated, has been largely instrumental in developing locally the famous Co-operative Societies, which in so many ways have been of assistance in improving the social and industrial conditions in this county and in many parts of Cape Breton. Somewhat similar to the co-operative movement developed to such an amazing extent in Denmark, Sweden, Great Britain and other countries, the members of these bodies have been enabled to reduce their cost of living either directly or by sharing in the profits.

Arrangements have now been effected whereby the St. Andrew's Co-operative Company, located at St. Andrew's, about eight miles from Antigonish, will pay a certain portion of the patronage dividends, that is the profits returned to their members, to St. Martha's Hospital at Antigonish and in return the hospital will provide the shareholders and their families with free ward service for an aggregate of five weeks in any one year, free ordinary medicine and free laboratory service. Patients desiring private rooms would receive them at half the regular rates, and the same 50% reduction will apply to X-ray service and operating room charges. For this service the Co-operative will pay the hospital on behalf of its shareholders—some 180 in number—the sum of $9.00 per annum per shareholder. Medical care, as in most plans of group hospitalization, will not be included, but will be a matter of arrangement with the family doctor. He, of course, will benefit indirectly by the elimination of the hospital account.

The St. Andrew's Co-operative is in a district which, including six or seven nearby villages, has a population of some 1,200. For the past five years this area has spent on hospital service approximately $1,200 per annum—or about one dollar per person. Obviously, this has meant minimum service, the cost preventing many from taking proper advantage of the nearby hospital facilities. It was agreed that adequate hospital service could be provided only by co-operative action and the St. Andrew's Company, a truly community effort, not only provides this basis but solves the problem of collecting premiums in a rural area where the pay-envelope "check-off" cannot be applied. Should the plan prove successful at St. Andrew's, it is proposed to make similar arrangements with other Co-operatives in other communities.

This would appear to be a very interesting variation of the principle of group hospitalization, which is now being developed in so many centers throughout the continent. The usual plan requires that the members pay the premiums for such service, either directly or by wage "drawbacks." This plan, however, would provide the premiums out of dividends accruing from participation in the co-operative movement. Such an arrangement, it would seem, should prove of value to both the hospital and the Co-operatives.

This plan will be followed with considerable interest. From the viewpoint of the hospital, a major consideration is assurance that the premium calculated to be necessary to cover the cost of service will be forthcoming, and in this instance we have been informed that the Co-operative is in a very healthy state financially. It must be borne in mind, also, that the enrollment of members of a co-operative plan would enroll individuals who are theoretically a greater risk actuarially than employed groups. Obviously, individual families will be enrolled and many of these may be chronically ill or temporarily unemployed. It is the general experience of sponsors of group hospitalization plans that morbidity risks are lowest among employed persons and, particularly, where members are accepted in groups only. It should be kept in mind, also, that it is more difficult to deal with a person or family entitled to hospital benefits as a member of another body than where such individual is enrolled in a hospital scheme directly and not indirectly through such other body. In one case it is very easy to discontinue the membership of a recalcitrant or undesirable individual; in the other the procedure may be more complicated. The co-operation of the medical profession will be of material assistance.

These, however, are minor difficulties which should be

subject to correction or for which allowances can be made, and should in no way affect the excellent principle underlying this development. Hospitals are endeavoring more and more to develop a basis of finance which will minimize the burden of hospital costs to the individual, and which will, in so doing, make the hospital more readily accessible to those who need its care. This linking up of the hospital with a widespread and rapidly growing co-operative community unit is typical of the progressive and co-operative spirit shown by the people in this area, and is a viewpoint which should be an inspiration to other hospitals and communities throughout Canada.

The Farmers' Creditors Arrangement Act and the Hospitals

PUBLIC hospitals throughout Canada and various hospital associations have protested on many occasions concerning the difficulties encountered by the hospitals with respect to the Farmers' Creditors Arrangement Act. This is a federal enactment, passed in 1934, whereby a farmer unable to meet his liabilities as they become due may make a proposal under this Act "for a composition, extension of time or scheme of arrangement either before or after an assignment has been made." This proposal is filed with the Official Receiver, who is empowered to convene a meeting of the creditors and arrange for such adjustment of the debts as would best meet the individual situation. On the filing with the Official Receiver of a proposal, no creditor, whether secured or unsecured, shall have any remedy against the debtor, or shall commence or continue any action, execution or other procedure for the recovery of a debt unless with leave of the court and on such terms as the court may impose. The limitations and exceptions provided for under this arrangement are set forth in the Act, as given in Chapter 53, 1934, and as amended by Chapter 20, 1935.

Hospitals are not listed as preferred or secured creditors and they repeatedly find, after having given extensive service to farmers, that where this enactment is invoked the hospitals either cannot collect their accounts or are asked to accept an unsatisfactory basis of payment. Our public hospitals are non-profit organizations, carrying at the present time a tremendous load of charity or non-pay work. Patients are brought to them of dire necessity, and the service for which they ask payment is a life-saving one and of untold value, both to the individual and to the state. It is fully realized that there are many instances in which there is little money for any person, the debts far outweighing the assets, but the hospitals do feel that the provision by them of services absolutely necessary for the welfare of the individual should have preference over many other accounts which are distinctly of a non-essential or even luxury nature.

Hospitals and provincial hospital associations have requested the Canadian Hospital Council to make application on their behalf to Ottawa, that the Farmers' Creditors Arrangement Act be so amended as to exempt debts due to hospitals, by patients, from the provisions of this Act. If this be not possible, the hospitals have indicated their strong desire that, at least, they be placed in a more favoured or secured position than they are at the present time. Acting on these requests, the Canadian Hospital Council took this matter up with the Minister of Finance, and the following reply was received. It is gratifying to the hospitals to know that the Government at Ottawa is taking this sympathetic view of the situation of our hospials, and it is hoped that future amendments will place the hospitals in a better position than at the present time.

"Department of Finance, Canada,
Ottawa, April 22, 1936.

Dear Dr. Agnew:

Your communication of the 20th instant, addressed to the Honourable the Minister of Finance, has been referred to me, relative to the disadvantage under which Canadian Hospitals may be placed attributable to the manner in which proposals submitted by farmers under the Farmers' Creditors Arrangement Act are dealt with by the Provincial Boards of Review.

The splendid services afforded to farmers throughout Canada by hospitals are fully recognized, not only by myself but by the Judges who act as Chairmen of these Boards and the individual members of such Boards.

In this connection, I may point out that it is only the farmer who is insolvent to a degree at least that he is unable to meet his liabilities as they fall due who is entitled to submit a proposal under the Farmers' Creditors Arrangement Act. Reductions in such farmers' debts are made only where such action becomes necessary to bring the farmer's obligations within his present and prospective capacity to pay.

All Boards of Review recognize the degree of priority or preference to which an hospital account is entitled beyond that consideration which may be given to other types of unsecured debts, particularly the obligations assumed by farmers for non-essentials or for luxuries.

The situation with respect to this question at the moment is simply this—the Farmers' Creditors Arrangement Act is the subject of reference to the Supreme Court of Canada with respect to the question of its validity. Should the Act be upheld it is the intention that prompt consideration will be given to such amendments as may be necessary to the Act itself and to the Regulations thereunder, at which time further and very careful consideration will be given to the representations submitted by you on behalf of the Canadian Hospital Council.

In the meantime, I am taking the liberty of forwarding a copy of your letter to all Boards of Review throughout Canada in order that the serious import of the situation may be given further consideration by them in dealing with present and future sittings of the Boards.

Yours very truly,
(Sgd.) H. F. Gordon."

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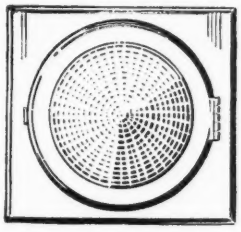

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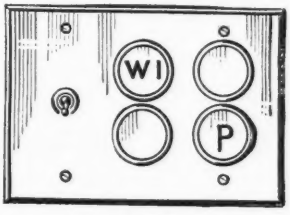

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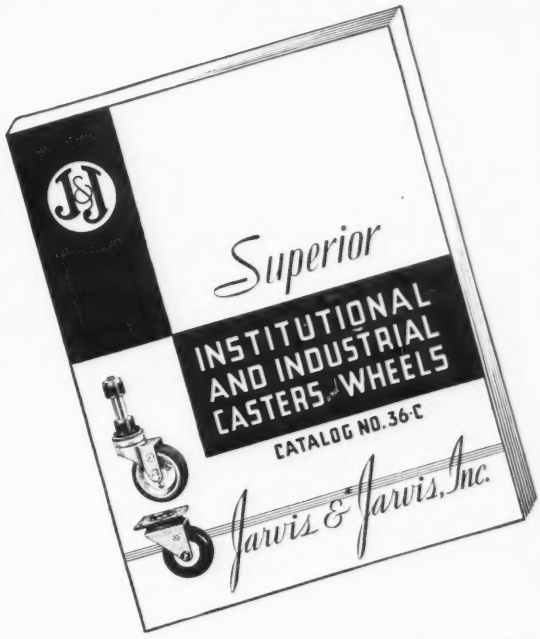

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WE WOULD LIKE TO KNOW—

The Editorial Board will be pleased to answer any question they can in this column that will be of general interest to hospital workers. Kindly mail questions directly to the Editor.

Q. What type of nurses' signal system do you recomend for a 65 bed hospital?

A. A signal system commonly used in the smaller hospital consists of a push-button situated at the bedside which, when pressed by the patient, activates a light over the patient's bed—over the patient's door—and a number on the annunciator board in the nurses' station, and at the same time sounds a buzzer to attract the attention of the nurse should she be away from the station. The signal when once made may only be cancelled at the bedside by the deliberate action of the nurse. Such a system is reasonable in price and efficient, for the light over the bed tells the patient that the system is working and if there is more than one bed in the room the nurse knows which patient has called, the light over the door attracts the attention of anyone passing, thus saving a walk to the annunciator to see who is calling. It can be operated on low or regular voltage lines.

Q. How can metal be satisfactorily stuck to glass for the purpose of repairing such articles as atomizers, etc.?

A. Litharge, mixed to a thick paste with glycerin, is very satisfactory for this purpose. It has the advantage in that it may be used to fill spaces to prevent leakage. The mend should be dried at a temperature of about 140° for a few hours after which it is safe to use even in alcoholic solutions, boiling water, etc.

Q. If a nurse who is not registered in the province comes to the hospital with a friend or relative whom she wishes to nurse, what stand should be taken in the matter?

A. A nurse who is not registered in the province should not be allowed to assume charge of a patient in the hospital. It is well for the governing body to legislate that only nurses registered in the province and community may practise their profession in the hospital. If the situation only arises occasionally it may be diplomatically overcome by allowing the nurse to wear a gown over her street clothes and sit with the patient. Usually the nurse in question is pleased to have the matter settled for her in this way since it is often a situation not of her own choosing.

Q. Is it good policy to destroy X-ray films after a reasonable number of years have elapsed since they were taken?

A. No. The clinical record (of which radiographs are a part) is created primarily in the interest of the patient and secondly as an educational and statistical aid. Therefore, as long as the patient is alive or the record can be of teaching value, even if only in a historical way, it must be kept and so indexed that it can be readily found.

Q. What is the meaning of the term "indigent"?

A. The exact meaning varies from province to province and a concise abstract definition is hard to frame. Usually a person is indigent when a comparison of his income and expenditures, assets and liabilities, shows that after making an allowance for necessary living expenses and the expenses of earning or producing his income, he cannot pay a hospital bill on reasonable terms. The existence of an income or the ownership of property does not by any means disprove indigency because pauperism or complete destitution is not necessary. See the provincial definitions in the Report of the Canadian Hospital Council committee on Legislation, Bulletin No. 9, pages 4 and 5.

Q. Should a hospital undertake to make laboratory examinations for non-medical doctors such as chiropractors?

A. Positively No. You should be struck from the list of approved hospitals if you do.

Q. Should the Admitting Department be held responsible for the collection of accounts from patients in the hospital?

A. No. The Admitting Department functions more efficiently if the duties of the clerks are restricted, as much as possible, to admitting, and better results can be obtained by having the Credit Department take charge of the account as soon as the patient has been admitted. It will, of course, be necessary to make exceptions in the case of smaller hospitals.

Q. How much time should student nurses spend in the Dietary Department during their training? What work should they cover during this period?

A. At least six, and preferably eight weeks of a three-year course should be spent in the Dietary Department. An excellent arrangement is to divide the period of training into two sections, the first term in the Dietary should be in the junior year following the lectures on Dietetics and Nutrition. The work in the Dietary should comprise of general food preparation, such as invalid foods, etc., preparation of infant formulae, tray service with emphasis on private and semi-private trays set up under the direction of senior students. The second term should be given over to the preparation of diabetic diets and special non-weighed diets. This work should follow lectures on Diet Therapy either in the student's intermediate or senior year. At the conclusion of their Dietary course students should be capable of preparing attractive meals for either "house" or "special" diet patients.

Q. How often should a hospital be audited and what is the best method of audit control?

A. A complete audit should be made at least once a year by a reliable firm of chartered accountants, although the statute governing the hospital or fidelity bonds covering employees may require more frequent external audits. A continuous internal audit is advisable, which could be largely a matter of daily routine.

Q. We have an X-ray machine capable of generating 150 K.V., can it be used for therapy?

A. A step-up transformer that can produce 150 K.V., if used through proper tubes and filters, is suitable for superficial and moderately deep roentgen therapy providing it is in trained hands. X-ray therapy when administered under the direction of a doctor specializing in radiotherapy can be of great value, but unless you have such a specialist in your community and a technician capable of interpreting his instructions with the greatest of accuracy, we strongly advise you not to attempt this type of treat-

(Continued on page 34)

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We Would Like to Know—

(Continued from page 32)

ment for irreparable harm can be done that may disable the patient and involve you in lawsuits. The makers of your machine and your nearest radiologist will be valuable consultants with you on this matter.

Q. Is a verbal "guarantee" of a hospital account legally enforceable?

A. If A is the patient and B merely guarantees that A will pay his account, this is a guarantee and must be in writing. In such a case, there are always two promises—A's promise to pay his account and B's promise to see that A pays. If, however, B promises unconditionally to pay the account, then this is not a guarantee and B's promise need not be in writing. The distinction is important when the negotiations must be conducted by telephone. It is then advisable to use the second form by asking B if he "will be responsible for the account" or if "the account may be charged" to him. If A also promises to pay in this case, that does not alter the nature of B's promise. You then have two joint debtors.

Q. We have recently installed a humidifier in our Children's Ward but have had to discontinue its use as the walls "sweat" to such an extent that the plaster is falling. What is the cause? Can it be remedied?

A. It is caused by a too high dew point. It can be remedied by increased ventilation. This may even have to be forced ventilation by fans. Decreasing the humidification will help to solve the problem. If this condensation upon the walls is noticed, particularly in the winter time, it may be due to poor insulation of the outside walls, in which case better insulation should be undertaken.

Q. Under what condition should a hospital insist upon a consultation being held?

A. Whenever there is the slightest doubt about the outcome of the case. Do everything in your power to encourage careful consultation work among the medical staff and see that a complete record of such consultation is embodied in the patient's chart. The consultation percentage is a good general index of medical staff proficiency.

Q. What is the relative reflecting power of the various colors commonly used in hospital decoration?

A. The following figures are taken from clean painted surfaces by means of a photometer at such an angle that gloss does not enter into the calculation.

White	— 84%	Buff	— 51.5%
Cream	— 68.8%	Light Gray	— 51.5%
Ivory	— 66.7%	Light Cream	— 45.2%
Yellow	— 57%	Light Blue	— 36.4%
Light Pink	— 66.5%	Aluminum	— 41%

The darker colours of the above shades range from 15% downwards.

Q. What are the features most worthy of investigation when contracting for a supply of coal?

A. (a) The B.T.U. value.
(b) The clinkering index. Fuel having too low an index will cause expensive grate replacements.
(c) The size most suitable for your type of heating plant.
(d) The ability of the mine to insure you a constant supply all the year or season round.

Tariff Changes of Interest to Hospitals

Under the Customs and Excise Tariff several changes, of interest to hospitals and doctors, were announced in the budget address of the Honourable, the Minister of Finance last month.

Item 206a. This item formerly read "bacteriological products or serum for subcutaneous injection," and was free under the various rate classifications. It now reads as follows:

"Biological products, animal or vegetable, n.o.p., for parenteral administration in the diagnosis or treatment of diseases of man, when manufactured under license of the Department of Pensions and National Health under regulations prescribed by the Food and Drugs Act. Free. Free. Free."

Until this item be interpreted, it cannot be announced what will be included under this heading, but for some time the Department of Hospital Service of the Canadian Medical Association and the Canadian Hospital Council have been requesting free entry of various bacteriological and other biological products for use in diagnosis or treatment. Particularly has there been a request for the free entry of protein sensitization tests. Workers in British Columbia, for instance, have found that plant extracts collected in the east have not had the same reaction as the Pacific Coast flora, and have been compelled to use United States products. Obviously, it is the desire of the government to protect the public in Canada from an inrush of unscientific biological products by the requirement that such be manufactured under license. It is anticipated that the free importation of certain parental liver extracts will be permitted under this item.

Item 476a. This item now reads as follows, the words in italics having been recently added:

"Glassware and other scientific apparatus for laboratory work in public hospitals; *chairs* and tables for surgical operating *purposes;* and complete parts thereof (rearranged); *infant incubators and complete parts thereof; electro cardiographs and complete parts thereof, and sensitized film and paper for use therein;* apparatus for sterilizing purposes, including bedpan washers and sterilizers, but not including washing or laundry machines; all for the use of any public hospital, under regulations prescribed by the Minister. Free. Free. Free.

Hospitals will be particularly pleased to notice the inclusion of infant incubators in the list for free entry.

Item 696a. The following item is a new one, which will be of interest to hospitals because of the increasing use of educational films. Item 696, with which it is associated, provides for the free entry of scientific apparatus and educational equipment for use in schools or hospitals.

"Educational moving picture films of all widths, silent or sound, positive or negative, and sound disks or records designed for use with such films, when certified by the Minister as entitled to exemption from Customs duty under the Convention for Facilitating the International Circulation of Films of an Educational Char-

acter; subject to such regulations as the Minister may prescribe. Free. Free. Free."

Under the Excise Act, there is a reduction of $1.00 per gallon in the rate of excise duty on spirits used in medicines, extracts, and pharmaceutical preparations, in order to bring it into line with the rate applying to spirits used in the manufacture of perfumes.

The proposed increase in the Sales Tax from 6% to 8% is of interest to hospitals, because of the exemption which they have enjoyed for some years from the payment of this tax. The exemption has been much appreciated during this period, and will be even more appreciated with the higher rate.

Be Careful What You Buy

IN both the April and May issue of "Hospitals" it is noted that there is Editorial comment on the persistence of certain manufacturers in forcing inferior merchandise upon the hospitals. Canadian hospitals cannot afford to ignore this warning, for with money so hard to get it is absolutely vital that it be spent in such a way that the maximum value is received. With so many reputable firms supplying the hospital field there is very little reason why we should enter other fields and start promiscuous purchasing. The reputation of firms we know has been built up by years of good service to our hospitals and we know they will stand behind the goods they supply and in the few instances where an inferior article is sold, in the interest of their future business, they will gladly make adjustments. This does not apply to some of the concerns who are continually breaking into the hospital field with supposedly good products at cheaper prices. Very often these products are represented as being approved for hospital use but the authority for such approval should be investigated rather than taken at its face value.

There are very few staple articles that we need in such a hurry that we cannot afford the time to find out who has used these articles and the results of such use. Any salesman who wants to close a deal before a proper investigation has been made should be viewed with a suspicious eye. Therefore we urge every hospital buyer to protect themselves and reputable firms that sell to them by carefully checking any products before purchasing and in the event of the purchase being made to let the hospital field know of the results after a reasonable trial. The Canadian Hospital Council will willingly give any information it may have on its files regarding equipment if you will write to them.

Institute for Hospital Administrators

The Institute for Hospital Administrators will be held this year from September 9th to September 23rd at the University of Chicago. The Institute will close in time to enable participants to get to the American Hospital Association Meeting in Cleveland on September 28th. The success of the Institute in past years makes it unnecessary to enumerate the advantages of attending the course. Members of the hospital field who are interested should get in touch with Dr. Bert W. Caldwell, Executive Secretary, American Hospital Association, 18 East Division Street, Chicago, to obtain application blanks and a syllabus of the course.

The Toronto Curative Workshop

M. OLIVE NOBLE,
Chief Therapist Curative Workshop, Toronto Occupational Therapy Association.

THE value of occupational therapy is gradually increasing as its application becomes more scientific. Due to the realization of the fact that specialization is as necessary to this profession as any other, research work is being conducted and the effect of every branch of occupational therapy being carefully recorded for future use. It is not enough to know that in some haphazard way the patient has improved, but what factors entering into the treatment were favorable and wherein the treatment was inclined to fail, which necessitiates a careful study of the personality of each individual, taking into consideration everything which might influence his choice and interest in an activity.

Because one psychasthenic patient is benefited through weaving, it does not follow that all such cases will derive from it equal satisfaction. The next patient of the same type might approach a more normal adjustment through his association with others in a group activity. Similarly two surgical cases with the same diagnosis cannot always be given the same type of work. Apart from the one governing factor of the patient's interest, the amount of movement in the muscle groups of each patient may differ enormously, one requiring fairly heavy work and the other light exercise. An interest which might at first appear an excellent form of sublimation, if not carefully supervised could possibly descend to the point where it only serves as a basis for the development of further delusions, just as easily and simply as an injured muscle could be overexercised.

The necessity therefore has arisen for therapists to specialize in one field in order that the doctor's prescription may be accurately followed, and valuable information on the patient's progress reported to him. With this supervision of all activities, it can eventually be ascertained, by observing the patients reactions exactly to what an extent and in what measure the treatment is most beneficial.

On this principle the Toronto Curative Workshop is being conducted with two specialized aides in charge of the patients—one who has specialized in work with surgical cases and the other in following the personality needs of mental patients. In addition, weekly clinics are held under the direction of a psychiatrist and an anatomist who prescribes treatment for city cases and those patients who are only able to visit their physicians at long intervals, making it possible for every patient to be treated under the continuous care of a doctor, and eradicating any weakness in the form of treatment. All types of cases are handled and the atmosphere of the workshop is made as normal as possible, with all the patients engaged in activities on a par with their capabilities, making attendance here a step in progression after discharge from the hospital. Although craft work is only one medium of treatment, an effort is made to make it as varied as possible and on a high modern level in accordance with the public demand, so that each patient will feel that he is engaged in constructing an article, not only artistic but of marketable value. The value of recreation and social activities has been fully recognized and classes organized solely for such purposes, particularly for mental patients in need of social adjustment. Transfers to various classes are arranged as the patient improves until the point is reached where the treatment develops into pre-vocational training, in which group at present some are engaged in learning dress-making and typewriting.

The mental and medical patients usually attend in groups, every patient being placed in the group which will be most helpful in the development of his personality, from which he may progress as he becomes more normally adjusted to a group on a higher level. In a like manner all their activities are graded, always on a level with the patient's maximum powers of concentration and intellection. The normalizing influence of play has been taken into consideration and a recreation room established, which is used for games, music and social affairs. The value of such group activities is emphasized by the improvement in the behaviour of a patient with definite paranoid tendencies, who has been attending the workshop for only a few weeks. At first her suspicions prevented her from attempting any kind of work and were far too powerful to allow her to even converse with the others in her group. Eventually her interest being gained in a form of craft work at which she worked fairly constantly, she began to make friendly comparisions with the work of others. Thus it formed the first link in a social adjustment, which is gradually developing normally. Crafts cannot be labelled according to the diagnosis of a mental patient, but the personality and environment of the individual studied before treatment can be given. At present two men in the same diagnostic category are engaged in entirely different forms of work, and yet both receive equal satisfaction from these pursuits. One apparently forgets his unreasonable fears in the careful and detailed construction of wooden articles, whereas the behaviour of the second man becomes more normal during recreation and discussion periods, where he finds self-expression. Medical cases are treated not only from the point of view of the mental condition which usually accompanies any physical disorder, but their work is strictly supervised and graded in order to counteract their tendency to overestimate their own strength when they are keenly interested.

In addition to the crafts and recreational facilities, there is also provided for the surgical cases a room for remedial exercises, which are directed through the doctor's prescription and supervised by the therapist. When this exercise period, which requires individual attention, is completed, the patient is given some task to perform which will exercise these same muscles and frequently exercise them unconsciously as the mind is engrossed in the work. One case of torticollis is learning to use the typewriter with the instructions pinned to the wall at her side so that whenever she refers to them it is necessary to use the affected muscles. In some cases which necessitate muscle re-education, the whole treatment consists of remedial exercises, first passive and then active and it may be many months before the patient is even able to attempt craft

work. A case of complete paralysis as the result of a brachial plexus injury was treated at home by a therapist who manipulated his hands and feet until he was able to walk with the help of others. Then he was persuaded to attend the workshop where the programme of muscle re-education is being continued. Although having attended regularly for three months, this man is not yet able to do constructive work due to the slow development of the shoulder and arm muscles, but he does show tremendous improvement inasmuch as he can walk up and down stairs with very little assistance, has learned to use the jig-saw, and even attempts pingpong. These cases also require careful supervising in order that the muscles will never be stretched or over-exercised.

To the hospital patient the workshop is the first step in progression from the hospital to his normal life, and to those who have not been hospitalized, it is treatment without the necessity of attending an institution. It is a step between the normal busy life and the idle uninteresting life of the invalid, providing new habits of thought for the mentally sick, and conserving the work habit for those on the border-line. Not only is it a valuable preventive measure for any community, but serves as a sheltered environment for any convalescent, placing his disabilities at a minimum, until he is able to take his place in the world once more, shortening his convalescence and lessening through graded occupations his sense of inferiority.

Book Reviews

"Hygiene and Sanitation," by George M. Price, M.D., Director of the Union Health Centre, New York City. This concise text, one of the "Nurses Textbook Series," has already proven its value and now appears in its sixth edition thoroughly revised. Previous editions have been very popular in a large number of the schools and it is safe to say that this edition contains revisions that make it even more valuable. The book is compact, 295 pages, and forcefully brings before the reader the value of prophylaxis. Obsolete techniques have been discarded and new and accepted ones replace them. A very valuable section is devoted to prophylaxis in cancer. We unconditionally recommend this textbook for teaching and library use on the reputation of its previous editions.

Published by Lea & Febiger, Washington Square, Philadelphia, P.A., 1936. 12 mo, 295 pages. Cloth, $2.25 net.

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"Physical Therapy for Nurses," by Richard Kovacs, M.D., Clinical Professor and Director of Physical Therapy, Polyclinic Medical School and Hospital, New York.

This is another of the "Nurses Textbook Series" by an outstanding writer. It brings before the reader in simple, concise phraseology the value of the physical phenomena, light, sound, heat and electricity as an aid to medicine. The book is recommended to those Schools of Nursing including Physical Therapy in their curriculum, and it should certainly be included in all nursing libraries and departments of Physical Therapy.

Published by Lea & Febriger, Washington Square, Philadelphia, P.A., 1936. 12 mo, 286 pages. Cloth, $2.75, net.

Here and There in the Hospital Field

HARVEY AGNEW, M.D.,
Secretary, Canadian Hospital Council.

ALBERTA.—According to an announcement of the Honourable E. C. Manning, Provincial Secretary, there is a possibility that the government may set up an insurance fund to meet the hospital and medical expenses of motorists injured in automobile accidents; this would be provided out of the $1.00 annual driver's license fee. It has been estimated that 50c. out of each dollar could provide a fund to meet these calls. The Provincial Secretary stated that not only would such insurance protect a motorist from law-suits, but hinted that it might be extended to include protection for passengers and others, besides the drivers of wrecked cars.

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ANNAPOLIS VALLEY, N.S.—Considerable hospital construction is being planned in this orchard district. The new hospital at Kentville, now being designed by Mr. B. Evan Parry, will have from twenty-five to thirty-five beds. The nearby hospital at Berwick is also to be enlarged to give more accommodation for patients and staff, and it is proposed also that the Soldiers' Memorial Hospital at Middleton, farther down the valley, should be enlarged to meet the demand for additional bed space.

HAMILTON, ONTARIO.—Some 800 doctors from various parts of Ontario assembled for an all-day clinic at the Hamilton General Hospital on April the 29th. An exceedingly good programme was arranged by the clinical staff of the hospital. Some 83 patients were demonstrated, and the visitors were shown some of the new equipment, including the 200,000 volt X-ray machine at the tumour clinic. Some 54 Hamilton and visiting doctors participated in this unique demonstration.

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MONTREAL, P.Q.—The Provincial Government has taken steps to annul the charter of the Montreal Hospital Charities, Limited, on the ground that it has been illegally operating a sweepstake. The Superior Court has granted the application of the Provincial Attorney-General to serve a writ of scire facias upon this organization.

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MONTREAL, P.Q.—The sad plight of the epileptic was stressed by Dr. Wilder Penfield, Director of the Neurological Institute, speaking at the annual meeting of the Montreal Industrial Institute for Epileptics. Due to the violent nature of the illness, persons afflicted cannot obtain hospitalization and are often forced into insane asy-

lums. These people, who are sane and otherwise normal, are forced to mingle with insane patients. He pointed out that there was a real need for farm colonies for epileptics in that province and thought the time was opportune to put on a drive for such farms.

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REGINA, SASK.—Opposition to revised provincial regulations permitting nursing schools in smaller hospitals was raised at the recent annual meeting of the Saskatchewan Registered Nurses' Association. A few years ago, the capacity requirement of hospitals with schools of nursing was raised to 70 beds but, despite protest, it was said, the government had lowered this requirement to 30 beds. The Chairman of the Provincial Joint Study Committee stated "This retrogressive step has aroused the deep concern of those who have striven to improve the environment upon which the student nurse must rely for the preparation which is to fit her to meet the needs of the community into which she is intimately thrust."

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TORONTO, ONT.—St. Michael's Hospital is preparing plans for a new addition for administration offices, Sisters' residence and private wards. The architect is Mr. W. L. Somerville.

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TORONTO, ONTARIO.—At the recent Canadian Public Health Conference, Dr. R. D. Defries of the University of Toronto School of Hygiene, stated that certain Canadian municipalities may, in the near future, experiment with the customary practice followed in Great Britain of issuing confidential death certificates. It was pointed out that, in countries where this system has been tried, there has been a noticeable increase in the registration of deaths from venereal diseases, alcoholism and the like. This announcement is of interest, because it is well known to medical and hospital workers that statistics, compiled from death certificates, do not always give a true picture of the actual causes of death.

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TORONTO, ONT.—Recently a five-year-old child died in a Toronto hospital during the administration of an anaesthetic. No blame was attached to anyone connected with the operation, as the evidence indicated that the child was suffering from status lymphaticus, a condition which is exceedingly difficult to note before operation. However, the Chief Coroner, Dr. M. M. Crawford, pointed out that there were practically no regulations in hospitals with respect to the administration of anaesthetics and suggested that the jury call for standard regulations covering anaesthetics for all hospitals receiving government aid. He suggested that such a suggestion would be welcomed by Queen's Park, and would probably get quick action. This recommendation was submitted by the Coroner's jury, and Dr. B. T. McGhie, Deputy Minister of Health for the Province, stated that it would be given consideration.

It is not easy to see to what extent workable regulations could be set up. Certification of physical examination by the anaesthetist could be required, but this is now done almost routinely by either the surgeon or the anaes-

thetist. Equipment could be inspected, especially where gas machines are used, but here there is no uniformity of opinion with respect to the value of grounding. Regulations regarding blood pressure readings and the use of the open cautery might be set up to advantage, but it is very doubtful what regulations could control deaths from status lymphaticus.

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VANCOUVER, B.C.—The Vancouver General Hospital is badly overcrowded and an extensive building programme is being arranged. In a recent survey, Dr. William H. Walsh, of Chicago, recommended an expansion of over $1,500,000. His proposals would add 300 additional beds, making a total of 1,387. It was suggested also that the Salvation Army's Grace Hospital be acquired to form an annex. The General Superintendent, Dr. A. K. Haywood, is now urging the construction of a new 500 bed, 6 storey, acute unit to cost approximately $1,000,000, an addition to the nurses' home to cost, with furnishings, $290,000, alterations to the present main building to permit housing of chronic and convalescent cases, increased facilities for power, heat and light to cost $100,000 and other alterations to the nurses' home and the provision of quarters for the interns.

* * *

WINDSOR, ONT.—Drug addiction was discussed at a recent service club meeting by Dr. H. A. Waite, Managing Director of the Women's Narcotic Relief Association of Detroit. He reviewed the extensive spread of drug addiction on this continent, and emphasized the relationship of drug addiction to juvenile crime. Morphine that would cost a doctor about 35c. will cost the addict about $2.50. Using as an example a Canadian boy who was taking about $20.00 worth of morphine a day, he pointed out that, inasmuch as crooked pawnbrokers would only give about 10% of the value of the articles pawned, it was necessary for this boy to steal the equivalent of $200.00 worth of goods per day to ease his craving. The possibility of acquiring the morphine habit while under hospital care for other conditions requiring sedatives was emphasized, and the increasing use of marijuana cigarettes by young people was strongly condemned. Dr. Waite made a strong plea for society to give them more specific consideration and to make greater efforts to help and rehabilitate those who have become addicted.

The Giving of Dangerous Drugs

The recent case in which a husband was awarded £100 damages against two nurses who caused the death of his wife by inadvertently administering six ounces of paraldehyde to her instead of the six drachms ordered, is one of much importance to hospital administrators. In the case in question, the hospital was absolved from responsibility on the ground that it had taken reasonable steps to obtain skilled nurses, and that the relationship of master and servant did not exist when the nurses were engaged in the administration of drugs. The judge was also of opinion that there was no obligation on the part of the hospital executive to exhibit notices stressing the rule that the giving of drugs was the work of a Sister or her deputy. Nevertheless, such a sad occurrence, distressing for all concerned, must call attention to the need for special care in such matters; and incidentally, it emphasizes the necessity for plain writing in the matter of symbols, as it was the mis-reading of the sign for drachms as the sign for ounces that furnished the occasion (though not the excuse) for the tragedy in question.

—The Hospital (London).

An Excellent Suggestion!

"I have heard it said that the work of a record librarian is a monotonous routine filled with gruesome detail, containing much pathology and spiced with postmortem findings. Such may be the view of the pessimist and inexperienced. But any work can be made beautiful by the interest and attitude of the individual engaged in its execution. Indeed, the names of flowers and vines are no more lofty and high-sounding, no more euphonious than much of the terminology common to record librarians. Susan Ertz points out this beauty in her delightful novel, 'Madame Claire.' Writing to a dear old friend who had phlebitis, she said:

"I am sorry you are feeling less well. How is the phlebitis? No one ought to suffer from anything with such a pretty name. Did you ever stop to think that the names of diseases and the names of flowers are very similar? For instance, I might say, 'Do come and see my garden. It is at its best now, and the double pneumonias are really wonderful. I suppose the mild winter had something to do with that. I am very proud of my trailing phlebitis, too, and the laryngitises and the deep purple quinsies that I put in last year are a joy to behold. The bed of asthmas and malarias that you used to admire is finer than ever this summer, and the dear little dropsies are all in bloom down by the lake, and make such a pretty showing with the blue of the anthrax behind them'."

I feel certain that a record librarian finds the same pleasure, happiness and beauty in her chosen field."

J. Dewey Lutes, F.A.C.H.A., in the Bulletin of the Association of Record Librarians of North America.

Oxygen Therapy

Oxygen therapy by means of the "funnel" method is considered wasteful and inefficient. Administration through nasal catheter is reasonably ideal especially if the oxygen is first passed through a humidifier. The oxygen tent is excellent in that it gives full control of all factors relative to this form of therapy as does the oxygen room although the latter, to economically justify itself, can only be used in large institutions.

THE BUYERS' DIRECTORY

A directory of reputable manufacturers and distributors of Equipment and Supplies for Hospitals. Your perusal of these announcements, together with other advertisements in this issue, will be appreciated.

Kirkland Lake Red Cross Hospital Annex Opened

The new $100,000 annex of the Kirkland Lake District Hospital, the largest of the 26 outpost hospitals operated by the Red Cross in Ontario was officially opened April the 28th. The new annex will have a capacity of 74 beds. It was financed by means of a donation of approximately $50,000 by the local mines and a debenture issue for a similar amount by Teck township.

Hospital is Closed at Smoky Lake, Alberta

The George McDougall Hospital, a 13-bed hospital at Smoky Lake, some 80 miles north-east of Edmonton, has been closed for an unlimited time, and it is said that the district is now left without medical and hospital assistance.

Dr. W. J. McLean Heads Westminster Hospital at London

Announcement has been made of the appointment of Dr. W. J. McLean to the post of chief medical officer at the Westminster Hospital, London, Ontario, a Dominion Hospital for War Veterans. Dr. McLean was associated with Dr. David H. Nichol, and will succeed to the post made vacant by Dr. Nichol's death some months ago, since which time he has been acting in the capacity of chief medical officer.

Hospital Chemist Honoured

Mr. J. Stuart Wilson, Director of the Biochemical Department of the Toronto Western Hospital, was recently elected Chairman of the Toronto Chemical Association, a very active body made up of chemists associated with the University of Toronto, and with all branches of chemistry in industry and in the professions.

Radiologist Awarded Three Months' Salary

Dr. Omar G. Hague, former Radiologist to St. Boniface Hospital, St. Boniface, Manitoba, was allowed an additional three months' salary from the hospital in a judgment delivered recently by Mr. Justice Dennistoun. It was stated that Dr. Hague had been dismissed with one month's salary, following a press statement by him supporting euthanasia. When this interview was given last autumn, the subject of legalized euthanasia was receiving considerable press prominence and comments on the advisability, or otherwise, of euthanasia were being frequently quoted. Counsel for the hospital argued that the public interview of the plaintiff had prejudicially affected the hospital and his action thus warranted his dismissal, but the court held that there was insufficient evidence to show that the plaintiff has violated the moral code by which all Catholic hospitals are governed, and His Lordship held that the professional man has a right to express himself on scientific affairs, if he wishes to do so.

Miss Lawrie of Regina, President of S.R.N.A.

Miss A. F. Lawrie, Superintendent of Nurses at the Regina General Hospital, was elected President of the Saskatchewan Registered Nurses' Association at their annual convention held in Regina last month. Mrs. M. A. Young of the Moose Jaw General Hospital and Sister O'Grady of St. Paul's Hospital, Saskatoon, were elected Vice-Presidents. Miss Margaret A. Ross of Regina was elected Secretary-Treasurer.

Report of Mental Institutions

The Third Annual Report of Mental Institutions, 1934, has just been published by the Dominion Bureau of Statistics. This book should be in every administrator's library. Copies may be obtained from the Institutional Statistics Branch, Dominion Bureau of Statistics, Ottawa.